

FILLED NOV 24 1941

STANDARD CERTIFICATE OF DEATH

State File No. 33377
8332

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1 **0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 Days**
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Leonard Wolff**
3. (b) If veteran, name war _____
3. (c) Social Security No. **490-01-1005**

4. Sex **m** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Theresa** 6. (c) Age of husband or wife if alive **13** years

7. Birth date of deceased **Dec. 31, 1886**
(Month) (Day) (Year)

8. AGE: Years **54** Months **9** Days **19**
If less than one day _____ hr. _____ min.

9. Birthplace **Hungary**
(City, town, or county) (State or foreign country)

10. Usual occupation **Carpenter**

11. Industry or business _____

12. Name **Jacob Wolff**

13. Birthplace **Hungary**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Hungary**
(City, town, or county) (State or foreign country)

16. (a) Informant **Theresa Wolff**

(b) Address **1035 Allen Ave.**

17. (a) **Burial** (b) Date thereof **Oct. 22 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter & Paul Cem.**

18. (a) Signature of funeral director **H. Weich**

(b) Address **2201 S. Grand Bl.**

19. (a) **OCT 21 1941** (b) **J. F. Prodek**
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1035 Allen Avenue**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **19**,
year **1941** hour **8:15** minute **A.** M.

21. I hereby certify that I attended the deceased from **October 13**, 19**41** to **October 19**, 19**41**;
that I last saw him alive on **October 19**, 19**41**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic (Glomerular) Nephritis**
Duration _____
Due to _____
Due to _____
Other conditions **Arteriosclerosis**
(Including pregnancy within 3 months of death)
Chronic Lung Abscess

Major findings: **non-T.B. cause unknown**
Of operations _____
Of autopsy **Chr. Glomerular Nephritis**
Arteriosclerosis, Lung Abscess

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury **0**
23. Signature **L. J. Mulligan** (M. D. or D. O.)
Address **1515 Lafayette Ave.** Date signed **10/20/41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Francis A. Williamson

Licensed Embalmer No. 3565

P. O. Address 7401 Zephyrus Dr

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.