S. No. 2
M—2-43
5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 1 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5903

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1615

1. PLACE OF DEATH:

(a) County

(b) City or town ST LOUIS MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST JOHNS HOSP O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 HRS - 45 MIN (Specify whether
In this community 21 HOURS
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Mo (b) County 17

(c) City or town ST. LOUIS. MO 95
(If outside city or town limits, write "RURAL")

(d) Street No. 5707 McPHERSON AVE
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country O

3. (a) PRINT FULL NAME THOMAS JOHN WOLKEN

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced X O

6. (b) Name of husband or wife X

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased FEB (Month) 15 (Day) 1944 (Year)

8. AGE: Years | Months | Days | If less than one day 21 hr. 45 min.

9. Birthplace ST LOUIS (City, town, or county) Mo O (State or foreign country)

10. Usual occupation X X

11. Industry or business X X

FATHER
12. Name JEROME B WOLKEN
13. Birthplace ST LOUIS (City, town, or county) Mo O (State or foreign country)

MOTHER
14. Maiden name BLANCHE PAULINE DOHENY
15. Birthplace HARVEY (City, town, or county) ILL (State or foreign country)

16. (a) Informant Jerome B. Wolken
(b) Address 5707 McPherson Ave

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB (Month) 17 (Day) 1944 (Year)
(c) Place: burial or cremation OLD ST PETER & PAUL

18. (a) Signature of funeral director Watson Bockeoy
(b) Address 6536 Clayton Rd.

19. (a) FEB 18 1944 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15 year 1944 hour 11 15 minute P. M.

21. I hereby certify that I attended the deceased from 2/15/44 1:30 a.m., 1944, to 2/15/44 - 11 P.M., 1944; that I last saw him alive on 2/15/44, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death General Atalectasis of lungs (spontaneous)	
Due to Prematurity	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

159

Major findings:
Of operations

Of autopsy Failure of lungs to expand with air (Atalectasis)

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Thos. O. Maly (M. D. or other)

Address 3102 So Grand Date signed 2/16/44

(Licensed Embalmer's Statement on Reverse Side)

1615

1615

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 Albert W. Hampe

Licensed Embalmer No. 1861

P. O. Address.....

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.