

V. S. No. 2
100M-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26292
State File No. 7884
Registrar's No.

FILED SEP 14 1945
Registration District No. 318 Primary Registration District No. 1003

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

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:
415 Clara Ave /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Rosa M. Wolfheim
3. (b) If veteran, name war _____
3. (c) Social Security No. NONE

4. Sex Female 5. Color or race W.
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife Moses Wolfheim
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 1 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 4 6 _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____
MOTHER FATHER { 12. Name Geo Manush
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Bressler
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sydney Cook
(b) Address 415 Clara

17. (a) Burial (b) Date thereof 9/9/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Mayer
(b) Address 4356 Lindell Blvd

19. (a) SEP 13 1945 (b) J. T. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 415 Clara
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7
year 1945 hour 11 minute - P. M.
21. I hereby certify that I attended the deceased from January
1945 to Sept 7 1945
that I last saw her alive on Sept 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of rectal colon
Cerebral hemorrhage
Due to _____
Due to 46 d

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

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? _____

23. Signature Jerome O. Cook (M. D. or other) _____
Address 508 N. Grand St Date signed 9/8/45

Duration
1 yr
16 hrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

John G. Gonski

Licensed Embalmer No. *3398*

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.