

3. No. 2
A-5-43
5-17-39
I X36671

FILED MAR 18 1946

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2121**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
De Paul Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)
2 Yrs 4 Mons 3 Days

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. **4148a Grove St.**
(If rural, give location)
 (e) Citizen of foreign country?..... **0** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Sharon, Sue, Wolf.**

3. (b) If veteran, name war.....
 3. (c) Social Security No. **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **1**
 year **1946** hour **4** minute **50** p.M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....
 that I last saw h..... alive on....., 19.....
 and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Child**

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

7. Birth date of deceased..... **Oct. 28 1943**
(Month) (Day) (Year)

Immediate cause of death.....
Bedsores of brain
Status Myocardio Scleroticus

Due to.....
 Due to.....

Other conditions (Include pregnancy within 3 months of death).....
6/4

Major findings: Of operations.....
 Of autopsy.....

PHYSICIAN
 Underline the cause to which death should be charged statistically.

8. AGE:

Years	Months	Days	If less than one day
2	4	3	hr. min.

9. Birthplace..... **St. Louis Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name **Russell Wolf**

13. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Clara Fister**

15. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr Russell Wolf**
 (b) Address **4148a Grove St.**

17. (a) **Burial** (b) Date thereof **3-5-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Goodhart & Goodhart**
 (b) Address **2228 St. Louis Ave**

19. (a) **MAR 4 1946** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

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 **Atkins & Taylor** (M. D. or other)
 Address **Ray Mo** Date signed **2/4/46**

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

117743

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 Marie A. Cashion
Licensed Embalmer No. 3949
P. O. Address St. Louis Mo

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.