

FILED JUL 3 1946
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5518**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(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. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 Day
(Specify whether years, months or days)

In this community 20 Day
years, months or days

3. (a) PRINT FULL NAME FRANK WOLK

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex MALE **5. Color or race** WHITE

6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife THERISA WOLK

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

7. Birth date of deceased MAY 20 1867
(Month) (Day) (Year)

8. AGE: Years 79 Months 0 Days 29
7 30 hr. --- min.

If less than one day

9. Birthplace ST. GENEVIEVE MO
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

MOTHER FATHER { **12. Name** FRANK WOLK

{ **13. Birthplace** GERMANY 4
(City, town, or county) (State or foreign country)

{ **14. Maiden name** UNKNOWN

{ **15. Birthplace** GERMANY 1
(City, town, or county) (State or foreign country)

16. (a) Informant Hilda Gaffney

(b) Address 4129 A N. NEWSTEAD

17. (a) BURIAL **(b) Date thereof** JUNE 22 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director Friedrich F. Home

(b) Address 8319 Halls Ferry Rd.

19. (a) JUN 21 1946 J. J. Bressack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

(c) City or town ST. LOUIS 107
(If outside city or town limits, write "RURAL")

(d) Street No. 4129 A N. NEWSTEAD 9
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19
year 1946 hour 6:45 minute A M.

21. I hereby certify that I attended the deceased from May 31
19 46 to June 19 19 46
that I last saw h. in alive on June 19 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart disease

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

23. Signature W. W. F. G. G. G. (M. D. or other) 0

Address 1515 Lafayette Avenue **Date signed** 6/19/46

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

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..... *W. Wilkinson*
Licensed Embalmer No. *3575*
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.