

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31495**  
Registrar's No. **1998**

Registration District No. **367** Primary Registration District No. **6076**

1. PLACE OF DEATH:  
(a) County **ST. LOUIS**  
(b) City or town **Lemay**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Christopher Drive**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **10** years, months or days)

3. (a) PRINT FULL NAME **Mrs. Stella Wolff**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Fred Wolff** 6. (c) Age of husband or wife if alive **45** years  
7. Birth date of deceased **October 14, 1900**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**45 11 9** hr. min.

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

10. Usual occupation **At Home**

11. Industry or business \_\_\_\_\_

12. Name **Walter Haas**

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

14. Maiden name **Barbara Stroessner**

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

16. (a) Informant **Mr. Fred Wolff**  
(b) Address **Christopher Drive, Lemay, Mo.**

17. (a) **Burial** (b) Date thereof **Sept. 26, 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Paul Churchyard**

18. (a) Signature of funeral director **Beiderwieden F. H., Inc.**  
(b) Address **1936 St. Louis Avenue**

19. (a) **9-26-46** (b) **Ruth A. Lee**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **Lemay**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Christopher Drive**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept.** day **23**, year **1946** hour **12:** minute **18 P.M.**  
21. I hereby certify that I attended the deceased from **9/21/46** to **Sept 23, 1946**  
that I last saw **her** alive on **Sept 23, 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**ac. dilatation of heart**  
**ac. Myocarditis**  
Due to **chronic vascular, coronary**  
Due to \_\_\_\_\_

Duration  
**30 min**  
**1 day**  
**seven yrs**

Other conditions **Ca metastasis to lung & ribs**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
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 \_\_\_\_\_

23. Signature **Dr. D. Trechius** (M. D. or other) \_\_\_\_\_  
Address **748 Lemay Ferry Rd** Date signed **9/28/46**

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

MOTHER FATHER

96  
0  
0

Dr. Ed Crecelius  
Lemay Ferry Road

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**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.....

*Glen W. Hat*

Licensed Embalmer No. *2737*

P. O. Address.....

*1936 St. Louis*

**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.**

Registration District No. 317 Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Jennay  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days)

3. (a) PRINT FULL NAME

Stella Wolf

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased Oct 14 1900  
(Month) (Day) (Year)

8. AGE: Years 45 Months 11 Days \_\_\_\_\_ (if less than one day) hr. min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M. 3

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Cancer metastatic  
(Include pregnancy within 3 months of death)  
To lungs - origin left

Major findings breast  
Of operation \_\_\_\_\_

PHYSICIAN

Of autopsy 50

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 \_\_\_\_\_

23. Signature Louis S. Ceccheri M.D. (M. D. or other) \_\_\_\_\_  
Address 148 R. Way, Tampa Date signed \_\_\_\_\_

SUPPLEMENTARY

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

20326

31495