

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7154**
Registrar's No. **1917**

Registration District No. **318** Primary Registration District No. **1003**

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:
City Infirmery
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 Yrs. 3 Mos.**
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Mo.**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5800 Arsenal St.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME: **Amelia Wohlert**

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 **Widow**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **May 30 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 ~~**75**~~ **8** **23** hr. min.

9: Birthplace **Poland**
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business.....

12. Name **Joseph Florposki**

13. Birthplace **Poland**
(City, town, or county) (State or foreign country)

14. Maiden name **Eva**

15: Birthplace **Poland**
(City, town, or county) (State or foreign country)

16. (a) Informant **City Infirmery Records**

(b) Address **5800 Arsenal St.**

17. (a) **BURIAL** (b) Date thereof **2 26 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY CEMETERY**

18. (a) Signature of funeral director **St. Louis Funeral Home**

(b) Address **2905 ST. LOUIS AVE**

19. (a) **FEB 25 1947** (b) **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **23**
year **1947** hour **3: 03 P.** minute..... M.

21. I hereby certify that I attended the deceased from **Oct. 18, 1945**, to **Feb. 23, 1947**,
that I last saw her alive on **Feb. 23, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral vascular accident** Duration **7 days**

Due to **Terminal bronchopneumonia** **8 days**

Due to.....

Other conditions **Terminal bronchopneumonia** **7 days**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: **850**
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?
While at work?..... (Specify type of place)
(e) Means of injury.....

Signature: **Julius Helmer** (M. D. or other) **M.D.**

Address **5600 Arsenal** Date signed **2/23/47**

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 *Ernest W Spillars*
Licensed Embalmer No. *4080*
P. O. Address *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. 318

Primary Registration District No. 1003

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:
(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

Amelia Wohler

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 Wid

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

7. Birth date of deceased May 30
(Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 2 (less than one day) hr. min.

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

10. Usual occupation Unemployed

11. Industry or business.....

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) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director J.F. Brebeck
(b) Address.....

19. (a) (Date received local registrar) (b) 1917
(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 CERTIFICATE

20. DATE OF DEATH, Month March year 1917 hour 3 minute 3 M.

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

Due to.....

Due to.....

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?
.....

While at work?..... (Specify type of place)
(c) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-7154