

No. 2
-12-45
5-17-39
I X47070

FILED APR 17 8 1947
68017 318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

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 - ex C. Starkloff Memorial
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community.....
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
 (c) City or town St. Louis 12/17
 (If outside city or town limits, write "RURAL")
4826a Delmar Blvd.,
 (If rural, give location)
 (d) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME EDWARD VOLKMANN

3. (b) If veteran, name war None 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Lydia Volkmann 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased April 21 1876
 (Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 3 If less than one day hr. min.

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

10. Usual occupation Architect

11. Industry or business

MOTHER FATHER
 12. Name Unknown 9
 13. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown 9
 15. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Victor Volkmann
 (b) Address 5079 South Broadway Apt. E

17. (a) Burial (b) Date thereof 3/26/47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laurel Hill Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 W. Washington Blvd.

19. (a) MAR 25 1947 J. F. Brediak
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd
 year 1947 hour 9:30 minute A M.

21. I hereby certify that I attended the deceased from 2/25/47
 to 3/23/47, 19....., to 3/23/47, 19.....;
 that I last saw him alive on 3/23/47, 19.....;
 and that death occurred on the date and hour stated above

Immediate cause of death Generalized gangrene Duration
 Due to rupture of suture line

Due to rupture of ca of colon
due to base to pelvic canal
 Other conditions (include pregnancy within 3 months of death)

Major findings: as above PHYSICIAN
 Of operations as above
 Of autopsy as above
 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? As above (Specify type of place) (M, D, or other)
 Means of injury As above

23. Signature 1515 Lafayette (M, D, or other)
 Address 3/26/47 Date signed

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

Henry M. Brammer

Licensed Embalmer No.

4200

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.