

No. 2
4-25
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X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 4 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **29691**
8039
Registrar's No.

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

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:
Winroot City Hospital # 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community **about 75 yrs.**
years, months or days)

3. (a) PRINT FULL NAME **Augusta Wolff (Zielinski)**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **NO**

4. Sex **Female** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **August Wolff**
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **8 11 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 0 11 hr. min.

9. Birthplace **Unknown** **Germany**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business.....
MOTHER FATHER { 12. Name **Michael Kuhl**
13. Birthplace **unknown** **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **unknown** **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr John-Zielinski**
(b) Address **2307 Howard St.**

17. (a) **Burial** (b) Date thereof **8-26-47**
(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) **AUG 25 1947** (b) **J. F. Brueck**
(Date received for burial) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **0100**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **2307 Howard St.** **9**
20 (If rural, give location) **0**
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8**, day **22**
year **1947** hour **6** minute **30** 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.

Immediate cause of death
Due to **Chronic Myocarditis**
Chronic Interstitial
Due to **Dehydration**
Other conditions (Include pregnancy within 3 months of death) **131**

Duration

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

(Specify type of place) **3**
(e) Means of injury.....
23. Signature **Calvert - E. J. Murphy**
Address **1514 E. 8th St. St. Louis**

me

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.....

John S. Penney

Licensed Embalmer No..... *4194*

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.