V. S. No. 2
50M—1/47
Rev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 7 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

36436
State File No.

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 10048

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: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson

(c) City or town Ste. Genevieve
(If outside city or town limits, write "RURAL")

(d) Street No. R.R.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Agnes Anna Wolk

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Albert J. Wolk

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased May (Month) 24 (Day) 1906 (Year)

8. AGE: Years 41 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Ste. Genevieve (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Henry Kreitler

13. Birthplace Ste. Genevieve (City, town, or county) Missouri (State or foreign country)

14. Maiden name Anna Schwent

15. Birthplace Ste. Genevieve (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Albert J. Wolk

(b) Address Ste. Genevieve, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-47 (Month) (Day) (Year)

(c) Place: burial or cremation Festus, Mo.

18. (a) Signature of funeral director Albert H. Honne

(b) Address 4700 Washington Blvd.

19. (a) OCT 30 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29th year 1947 hour 3 minute 55 A.M.

21. I hereby certify that I attended the deceased from Oct. 29 1947, to Oct. 29 1947, that I last saw her alive on Oct. 29 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage Bilateral Cavitation — Duration 6 months 2 weeks

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) T.B.

Major findings: Of operations None

Of autopsy None done

PHYSICIAN — Underline the cause of 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)

While at work? (e) Means of injury

23. Signature Reuben M. Smith (M. D. or other) M.D.

Address 4145 S. Grand Date signed 10/30/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 18 1962

OCT 14 1948

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. Spillers

Licensed Embalmer No. 4080

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.