

No. 300
-10-47
5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14804**
Registrar's No. **4087**

FILED MAY 11 1948

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **5370 Pershing Ave.**
(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 **Samuel L. Wolfort**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if _____
alive _____ years
7. Birth date of deceased **March 29 1873**
(Month) (Day) (Year)

8. AGE: Years **75** Months **7** Days **30**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Salesman**

11. Industry or business _____

12. Name **Henry Wolfort**

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

14. Maiden name **Hannah Waterman**

15. Birthplace **Boston Mass.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Leo Wolfort**

(b) Address **5370 Pershing Ave.**

17. (a) **Burial** (b) Date thereof **5-2-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Sinai Cemetery**

18. (a) Signature of funeral director **Herman Rindskopf, Inc.**

(b) Address **5216 Delmar Blvd.**

19. (a) **APR 30 1948** (b) **J. F. Breneck**
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Gas 17**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **5370 Pershing Ave.** (If rural, give location)
(e) **12** of foreign country? (Yes or No) _____
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **29**
year **1948** hour _____ minute **0** M.

I hereby certify that I attended the deceased from **Jan 1** 19**48** to **April 28** 19**48**
that I last saw him alive on **April 28** 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**
Due to **Arterio. Sclerosis**
Due to **Senility**
Other conditions (Include pregnancy within 3 months of death) **94**

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? _____
While at work? _____ (Specify type of place) (e) Means of injury **0**
23. Signature **Harry Sander** (M. D. or other) _____
Address **6348 Grand Blvd.** Date signed **4-29-48**

Shelf

8810-06

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 Ketter*
Licensed Embalmer No. *3880*
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.

Registration District No. 314 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 Samuel J. Wolfert

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

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

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

7. Birth date of deceased March 2 1943
(Month) (Day) (Year)

8. AGE: Years 15 Months Days If less than one day
hr. min.

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

10. Usual occupation Student

11. Industry or business.....

12. Name.....

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

14. Maiden name..... (State or foreign country)

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) 5-13-48 (b) J.F. Bredeck
(Date received local registrar) (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 April 19 1943
year hour minute M.

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

Duration

Due to.....

Due to.....

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

PHYSICIAN

Major findings:
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.....

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

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

SUPPLEMENTARY

MOTHER FATHER

S-14804