

No. 309
-10-47
-17-39
3908

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:
AT HOME 7201 N. BROADWAY
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution **NONE**
(Specify whether)
In this community **1 1/2 Yrs.**
years, months or days

3. (a) PRINT FULL NAME **ANTON P. WOLK**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **VERA WOLK** 6. (c) Age of husband or wife if alive **43** years
7. Birth date of deceased **NOV. 29 1898**
(Month) (Day) (Year)

8. AGE: Years **49** Months **8** Days **14** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Co. MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **GATE KEEPER AT CEM.**

11. Industry or business _____
12. Name **BENARD WOLK**
13. Birthplace **GERMANY** **4**
(City, town, or county) (State or foreign country)
14. Maiden name **WIN. KNOWN ZERWICK**
15. Birthplace **GERMANY**
(City, town, or county) (State or foreign country)

16. (a) Informant **Vera Wolk**
(b) Address **7201 N. Broadway**

17. (a) **BURIAL** (b) Date thereof **Aug. 16-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BELLEFONTAINE CEM.**

18. (a) Signature of funeral director **Diedrich F. Jones**
(b) Address **8319 St. Charles Ferry Rd.**

19. (a) **AUG 14 1948** (b) **J. F. Presbeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **7201 N. BROADWAY**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **16** year **1948** hour **9:15** minute _____ P. M.
21. I hereby certify that I attended the deceased from **April 17** to **Aug 17**, 19**48**
that I last saw him alive on **Aug 17**, 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Multiple Sclerosis**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

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) Means of injury _____
23. Signature **Arthur Belady** (M. D. or other) **8/13/48**
Address **2739 7th Street** Date signed _____

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

MOTHER, FATHER

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 *Frank J. Hand*
Licensed Embalmer No. *2645*
P. O. Address *St Louis Mo*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Sept.

Registration District No.

Primary Registration District No.

Registrar's No. 7154

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:
 (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 Anton Walk

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
hr. min.9. Birthplace.....
(City, town, or county) (State or foreign country)

10. Usual occupation.....

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) Address.....

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

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

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b) J. F. Breckner
(Date received local registrar) (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 1948 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
 that I last saw him..... alive on....., 19.....
 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)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)

While at work?..... (e) Means of injury.....

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

Address..... Date signed.....

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

SUPPLEMENTARY

SEP 9 1948

28351

115-200