

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14312

3566

BIRTH MO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1002		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Franklin			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) New Haven			
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) Katie		b. (Middle) _____		c. (Last) Wolfe		4. DATE OF DEATH (Month) 4 (Day) 19 (Year) 1949	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 18, 1883	
9. AGE (In years last birthday) 66		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Warren Co., Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Henry Buerger		13b. MOTHER'S MAIDEN NAME Caroline Suedermisson		14. NAME OF HUSBAND OR WIFE Oscar Wolfe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Oscar Wolfe, New Haven, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Arteriosclerosis Cardiovascular Disease DUE TO (c) Cardiac Decompensation II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 12 hours ? 1 mo. 3 days	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 940			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 42-11			
22. I hereby certify that I attended the deceased from March 16, 1949, to April 19, 1949, that I last saw the deceased alive on April 19, 1949, and that death occurred at 9:45 A.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Charles E. Mueller M.D.</i>				23b. ADDRESS 634 N. Grand, St. Louis 3, Mo.		23c. DATE SIGNED 4/19/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-23-49		24c. NAME OF CEMETERY OR CREMATORY St. Peters		24d. LOCATION (City, town, or county) (State) New Haven, Mo.	
DATE REC'D BY LOCAL REG. APR 20 1949		REGISTRAR'S SIGNATURE <i>J B Lassiter</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.			

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

NR.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Robert M Murray

Signed _____
Student Embalmer

Licensed Embalmer No. *3749*

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.