

FILED MAY 28 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18227  
Registrar's No. 894

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Affton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Affton	
d. FULL NAME OF HOSPITAL OR INSTITUTION 360 Tesson Ferry Rd		d. STREET ADDRESS (If rural, give location) 360 Tesson Ferry Rd.	
3. NAME OF DECEASED a. (First) Maria (Type or Print)		b. (Middle) _____ c. (Last) Wolschshauser	
4. DATE OF DEATH (Month) (Day) (Year) April 12, 1949			
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 30, 1900
9. AGE (In years last birthday) 48		IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME Joseph Kaiser		13b. MOTHER'S MAIDEN NAME Anna Hartel	
14. NAME OF HUSBAND OR WIFE George Wolschshauser			
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. _____	
17. INFORMANT'S SIGNATURE OR NAME George Wolschshauser		ADDRESS 360 Tesson Fer	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, uterus  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 172K DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 486	
19a. DATE OF OPERATION Aug 1948		19b. MAJOR FINDINGS OF OPERATION Carcinoma, uterus	
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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from Aug 1, 1948, to April 12, 1949, that I last saw the deceased alive on 4-10-49, and that death occurred at 5:30 A.M., from the causes and on the date stated above.			
23a. SIGNATURE W. Kiepper M.D.		23b. ADDRESS 4500 Olive St	
23c. DATE SIGNED 4-12-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 4/15/49	
24c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. 4-13-49		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE Ziegenhein & Sons		ADDRESS 7027 Gravois	

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

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**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 W G Peterson.....

Signed.....

Student Embalmer

Licensed Embalmer No. 3767.....

P. O. Address 7027 Gravois.....

**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.