

FILED JUL 26 1951

318

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE Missouri b. COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219

d. FULL NAME OF HOSPITAL OR INSTITUTION 1434 Hogan St.

2/ STREET ADDRESS (If rural, give location) 1434 Hogan St

3. NAME OF DECEASED  
a. (First) Alice b. (Middle) B. c. (Last) Wolf

4. DATE OF DEATH (Month) (Day) (Year) 7-3-51

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 8-6-1907

9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 43

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) St. Louis Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Simon Nowicki

13b. MOTHER'S MAIDEN NAME Bettye Batazak

14. NAME OF HUSBAND OR WIFE Andrew Wolf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) \_\_\_\_\_

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Andrew Wolf 1434 Hogan St.

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Carcinomatosis

INTERVAL BETWEEN ONSET AND DEATH 4 months

\*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.

ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) Carcinoma of Left Breast

1 year

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.  
Edema of Extremities

1 month

19a. DATE OF OPERATION \_\_\_\_\_

19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 170X

22. I hereby certify that I attended the deceased from July 1, 1951, to July 3, 1951, that I last saw the deceased alive on July 3, 1951, and that death occurred at 9:30P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Anthony A. Paskowski M.D.

23b. ADDRESS 1525 a Cass Ave

23c. DATE SIGNED 7-5-51

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 7-7-51

24c. NAME OF CEMETERY OR CREMATORY Cabary Cemetery

24d. LOCATION (City, town, or county) (State) St. Louis Missouri

DATE RECD BY LOCAL REGISTERAR'S SIGNATURE J. B. Proster

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Central Funeral Home 1841 Cass Ave

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

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.

Student .....

Student Embalmer

Signed

*John J. Haines*

Licensed Embalmer No. *4608*

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.