

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34244**

FILED SEP 24 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8697**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis, Missouri</b> ) c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>4236 West Pine st.</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>LOLLIE</b> b. (Middle) <b>VOLLAND</b> c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <b>SEPTEMBER 4, 1953</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Aug 25, 1878</b>
9. AGE (In years as of birthday) <b>75</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) <b>Texas</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Robert Berger</b>	
13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Frederick Volland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Frederick Volland, 4236 W. Pine</b>		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Vascular Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS	
ANTECEDENT CAUSES		DUE TO (b) <b>Gen. Atherosclerosis</b>	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)	
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <b>332 X</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 <b>8-31-53</b> , 19____, to <b>9-4-53</b> , 19____, that I last saw the deceased alive on <b>9-4-53</b> , 19____, and that death occurred at <b>5:10P</b> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Edward P. Selwyn M.D.</b>		23b. ADDRESS <b>1515 Lafayette Avenue</b>	
23c. DATE SIGNED <b>9-5-53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>9-8-53</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>	
DATE REC'D BY LOCAL REG. <b>SEP 8 1953</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Alexander &amp; Sons</b>		ADDRESS <b>6175 Delmar</b>	

(Licensed Embalmer's Statement on Reverse Side)

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..

Student.....  
Signature of Student Embalmer

Signed *Don E. Wagoner*

Licensed Embalmer No. *436*

P. O. Address *Haris*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.