

FILED AUG 23 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29411

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 517 PRIMARY REG. DIST. NO. 547 Registrar's No. 1920

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____	
b. CITY OR TOWN <b>Richmond Hts.</b>	c. LENGTH OF STAY (in this place) <b>1 Hour</b>	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. Mary's Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>5443 Winona Ave.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNA</b> b. (Middle) <b>M.</b> c. (Last) <b>WOLF</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 5 1954</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Jan. 8, 1876</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Carlinville, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			

13a. FATHER'S NAME <b>Nicholas P. Schaefer</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Mees</b>	14. NAME OF HUSBAND OR WIFE <b>Late Vincent C. Wolf</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Joseph J. Wolf</b>
		ADDRESS <b>5107 Lenox-Shrewsbury</b>

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension, arteriosclerosis</b>		<b>estimated 10 yrs</b>
	DUE TO (c) <b>Arteriosclerosis general</b>		<b>estimated 10 yrs</b>
	II. OTHER SIGNIFICANT CONDITIONS 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 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 July 10, 1954, to Aug 5, 1954, that I last saw the deceased alive on Aug 5, 1954, and that death occurred at 10:25 A.M., from the causes and on the date stated above.

23a. SIGNATURE <b>CH Bockelman M.D.</b> (Degree or title)	23b. ADDRESS <b>2615 Brentwood Blvd.</b>	23c. DATE SIGNED <b>8/6/54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Aug. 9, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>
		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>

DATE REC'D BY LOCAL REG. <b>8/6/54</b>	REGISTRAR'S SIGNATURE <b>Walter R. ...</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser</b>	ADDRESS <b>4228 S. Kingshighway Bl.</b>
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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 Paul A. Johnson

Licensed Embalmer No. 453

P. O. Address .....

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.