

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6629**
Registrar's No. **1721**

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| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | 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 _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) _____ | | c. CITY OR TOWN St. Louis | | d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital 0 | | | | e. STREET ADDRESS (If rural, give location) 2209 2506 E. Sullivan Ave., | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH | | b. (Middle) _____ | | c. (Last) WOLLENBERG | | 4. DATE OF DEATH (Month) (Day) (Year) Feb. 21st. 1955 | |
| 5. SEX Male 0 | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH March 2nd, 1897 | |
| 9. AGE (In years last birthday) 57 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo., 0 | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME John Wollenberg | | 13b. MOTHER'S MAIDEN NAME Frances Yashinska | | 14. NAME OF HUSBAND OR WIFE Mary Wollenberg | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. .492-07-2169 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Wollenberg 2506 E. Sullivan Ave., | | | |
| 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) ESOPHOGEAL VARIX HEMORRHAGE ANTECEDENT CAUSES DUE TO (b) CIRRHOSIS LIVER DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH 3 DAYS. UNK | |
| 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) _____ | | 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? 5810 | | | | 22. I hereby certify that I attended the deceased from 2/20/1955 , to 2/21/1955 , that I last saw the deceased alive on 2/21/1955 , and that death occurred at 11:30 p. m. , from the causes and on the date stated above. | |
| 23a. SIGNATURE (Degree or title) Henry J. Cooper M.D. 0 | | 23b. ADDRESS 511 Olive St. | | 23c. DATE SIGNED Feb 21 1955 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 2/25/55 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo., | |
| DATE REC'D BY LOCAL REG. FEB 23 1955 | | REGISTRAR'S SIGNATURE Robert Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leidner Undertaking Co. 2223 St. Louis Av. | | | |

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.....
Signature of Student Embalmer

Signed *Stanley H. Dixon*.....

Licensed Embalmer No. *419*.....

P. O. Address *St. Louis*.....

**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.**