

FILED APR 12 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11971

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>796</u>			
1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u>				b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Gardenville</u> )			c. LENGTH OF STAY (in this place) <u>50 yrs</u>		c. CITY OR TOWN <u>Gardenville</u>		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 <u>5211 Heege</u>				e. STREET ADDRESS (If rural, give location) <u>5211 Heege</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mamie</u>			b. (Middle)		c. (Last) <u>Wolz</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 22, 1956</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>May 14, 1877</u>		9. AGE (In years last birthday) <u>78</u> 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) <u>At home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Marshall, Mo.</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Peter Klein</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Schindler</u>			14. NAME OF HUSBAND/OR WIFE <u>Florian Wolz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Florence Gulath</u>			ADDRESS <u>4300 Tesson</u>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cerebrovascular Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardio-Vascular Disease</u>				3 yrs.	
				DUE TO (c)					
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Osteoporosis</u>				?	
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. HOW DID INJURY OCCUR?			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I hereby certify that I attended the deceased from <u>July 4, 1953</u> , to <u>Mar 22, 1956</u> , that I last saw the deceased alive on <u>3/29/1956</u> , and that death occurred at <u>11:35A</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>H. Schumann</u>				23b. ADDRESS <u>6811 1/2 Garrison Ave</u>			23c. DATE SIGNED <u>3/23/56</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3/26/56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>N St Marcus Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis Co, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>3-24-56</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Dombard</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J L Ziegenhein &amp; Sons 7027 Gravois</u>				

(Licensed Informer's Statement on Reverse Side)

✓ 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.....  
*Ronald E. Benz*

Licensed Embalmer No. *480*

P. O. Address *7027*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.