

FILED MAY 8 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14991**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4024**

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 town)	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis,	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) 4032 N. Grand Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) Alma	b. (Middle) Anna	c. (Last) Wolfgram	4. DATE OF DEATH (Month) (Day) (Year) April 23, 1956
-------------------------------------	---------------------------	----------------------------	------------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 19, 1909	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min. 46
-------------------------	----------------------------------	--	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois,	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	---

13a. FATHER'S NAME Frank Brown	13b. MOTHER'S MAIDEN NAME Kate Haslop	14. NAME OF HUSBAND OR WIFE Roy Wolfgram
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. Nil.	17. INFORMANT'S SIGNATURE OR NAME Roy Wolfgram,	ADDRESS 4032 N. Grand 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 20 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolus		
	ANTECEDENT CAUSES DUE TO (b) Rheumatic Heart Disease Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		
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 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) 416X
--	--	--

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 **March 26, 1956**, to **April 23, 1956**, that I last saw the deceased alive on **April 23, 1956**, and that death occurred at **12:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <i>C. P. Villian, M.D.</i>	(Degree or title) M. D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 4/23/56
--	-----------------------------------	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-23-56	24c. NAME OF CEMETERY OR CREMATORY Local Cemetery	24d. LOCATION (City, town, or county) (State) Licking, Mo.
---	-----------------------------	---	--

DATE REC'D BY LOCAL REG. APR 23 1956	REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Albert H. Hoppe</i>	ADDRESS 4700 Washington,
--	--	--	------------------------------------

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

MAY 8 1956

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..... *Elmo R. Cadwell*

Licensed Embalmer No. *407*.....

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.