

FILED APR 9 1958

Registration District No. **318** Primary Registration District No. **1003**

Registrar's No. **3698**

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, give TOWNSHIP only) OR TOWN ST. LOUIS MO		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 6029 CARLSBAD		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 02 29 6029 CARLSBAD	
3. NAME OF DECEASED (Type or print) First Middle Last MARY SUSAN WOLF			4. DATE OF DEATH Month Day Year APRIL 1 1958		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 7 1958	9. AGE (In years last birthday) 1	FUNDER 1 YEAR Months Days Hours Min. 1 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST. LOUIS MO U.S.A.	
13a. FATHER'S NAME GERALD E WOLF		13b. MOTHER'S MAIDEN NAME MARY H. SPIES		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address GERALD WOLF 6029 CARLSBAD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Condition, if any, which gave rise to above (b) DUE TO (b) _____ stating the underlying cause (c) DUE TO (c) 493X					INTERVAL BETWEEN ONSET AND DEATH 7 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 3-7-58 to 4-1-58 and last saw her alive on 3-15-58 Death occurred at 10 a m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) D. Dworkin M.D.			22b. ADDRESS 1657 So Grand		22c. DATE SIGNED 4-1-58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Apr. 2 1958		23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul	
24. FUNERAL DIRECTOR Thomas Ruth		ADDRESS 2906 Geavis		25. DATE RECD. BY LOCAL REG. APR 2 58	
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. M. J. B.					

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. Willie Dugan

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 *Not Embalmed*
Signature of Student Embalmer

Signed *Thomas F. Cline*

Licensed Embalmer No.....

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.