

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023900

STATE FILE NUMBER

FILED JUN 30 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5670

S. 300
v. 1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 14 Jewish Hosp.		Length of stay in lb 1 day	d. STREET ADDRESS 27 8786 W. Kingsbury
3. NAME OF DECEASED (Type or print) First Middle Last WOLFF MINNA L. WOLFF		4. DATE OF DEATH Month Day Year June 1, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years) 57 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
13a. FATHER'S NAME Benj. White		13b. MOTHER'S MAIDEN NAME Esther Rice	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
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. None	12. CITIZEN OF WHAT COUNTRY? USA
17. INFORMANT Carlyle Wolff 8786 W Kingsbury		14. NAME OF HUSBAND OR WIFE Carlyle	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO (b) <u>Adeno carcinoma Breast</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>170x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
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 <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 <u>1948</u> to <u>June 1, 1958</u> and last saw her alive on <u>June 1, 1958</u> Death occurred at <u>6:45 AM.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Malvin B. Kinstern M.D.</u>		22b. ADDRESS <u>950 Francis Pl.</u>	22c. DATE SIGNED <u>6-1-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE <u>6/2/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ch evra Kadasha</u>	23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherspn</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 2 '58</u>	26. REGISTRAR'S SIGNATURE <u>Carlyle Smith M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

JUL 14 1958

VS MAY 18 1959

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 *Elmer A. Gagnier*

Licensed Embalmer No. 4077

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.