

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015994

STATE FILE NUMBER

2 3339

LED APR 20 1959 Registration District No. Primary Registration District No. Registration No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Jackson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS (If outside, give location) R.R. #2	

3. NAME OF DECEASED (Type or print) First Middle Last Irene Wolfenkoehler			4. DATE OF DEATH Month Day Year April 2-1959		
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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 Jan. 23-1906	9. AGE (In years last birthday) 53	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Jackson, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME August H. Fredrich	13b. MOTHER'S MAIDEN NAME Martha Snider	14. NAME OF HUSBAND OR WIFE Albert Wolfenkoehler
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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	17. INFORMANT Albert Wolfenkoehler	Address R.R. #2 Jackson, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brown tumor (metastatic)		INTERVAL BETWEEN ONSET AND DEATH 1992
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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.)
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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
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21. I attended the deceased from 3-12-59 to 4-2-59 and last saw her alive on 4-2-59 Death occurred at 3:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE G. A. Amolue (Degree or title)	22b. ADDRESS 100 No. Euclid, St. Louis, Mo	22c. DATE SIGNED 4-3-59
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23a. BURIAL CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/3/59	23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	23d. LOCATION (City, town, or county) (State) Jackson, Missouri
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24. FUNERAL DIRECTOR Cracraft-Miller, Jackson, Mo	25. DATE RECD. BY LOCAL REG. APR 3 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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Dr. general tumor malignent, etc unknown
All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

2086

Dr. E. A. Smolik
100 No. Euclid Ave
Fo. 7-4031
After 3 P.M.

VS NOV 1 1960

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 *Jos. E. McCulloch*

Licensed Embalmer No. *2760*

P. O. Address *6175 P. M.*

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.