

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027373

FILED VS AUG 13 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7108** STATE FILE NUMBER

IDED

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		Length of stay in lb		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5387 Pershing			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Albert Middle J. Last Wolf				4. DATE OF DEATH Month July Day 30, Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/28/1880	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist			10b. KIND OF BUSINESS OR INDUSTRY Machinery Co.		11. BIRTHPLACE (City and state or country) Fowler, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME John Wolf			13b. MOTHER'S MAIDEN NAME Mary Schlipman			14. NAME OF HUSBAND OR WIFE Byrdie Wolf	
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. 493-05-5577		17. INFORMANT Ruth Wolf, 5387 Pershing		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Right Leg. DUE TO (b) Generalized arteriosclerosis DUE TO (c) Senility Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Following fall						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) was struck by sharp patient at Chicago Hospital					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 7:17 a.m.	Month, Day, Year July 17, 1959	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Shop	20f. CITY, TOWN, OR LOCATION St. Louis Mo.	COUNTY _____ STATE _____		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 1055A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Date) Paul Simon 8/1/59				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 7/31/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-1-59	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)	
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. JUL 3 1'59		26. REGISTRAR'S SIGNATURE Paul Smith, M.D.		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

277 23

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Edmond P. Padu

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 co
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.