

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS MAR 25 1960

60-013430  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **2810**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <del>St. Louis</del>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>15 Yrs.</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3623a Cleon Ave.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3623a Cleon</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Wolz</b> Last <b>Wolz</b>			4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1960</b>	
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> <b>Never Married</b>	8. DATE OF BIRTH <b>1-26-1908</b>	9. AGE (last birthday) <b>52 Yrs</b>	IF UNDER 1 YEAR Months <b>1</b> Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Surg. Supply</b>	11. BIRTHPLACE (City and state or country) <b>Granite City</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Adam Wolz.</b>	13b. MOTHER'S MAIDEN NAME <b>Katherine Dippel</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>318-12-1914</b>	17. INFORMANT <b>Ann Johnston</b> Address <b>2009 Clark Granite City, Ill.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Cerebral Hemorrhage</b>	
DUE TO (b)	<b>Arterio sclerosis</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	<b>331 X</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.  
Death occurred at \_\_\_\_\_ **1055 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Patrick J. Taylor</b>	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>3.10.60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-10-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Granite City, Ill.</b>
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24. FUNERAL DIRECTOR <b>Leonard R. Davis</b> ADDRESS <b>21st &amp; Cleveland</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 10 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>
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Granite City, Ill (Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Leonard R. Davis

Licensed Embalmer No. 4954

P. O. Address 1141st + Cl  
Granite

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.