

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013438

FILED VS APR 5 1960

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **3220**

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 1b	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 4547 Claxton Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last CARL AUGUST WULKOPF			4. DATE OF DEATH Month Day Year March 18th, 1960		
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5. SEX Male	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 8/19/1904	9. AGE (last birthday) 55	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk	10b. KIND OF BUSINESS OR INDUSTRY J.R. Kearney Co.	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Adolph Wulkopf	13b. MOTHER'S MAIDEN NAME Adele Siebenman	14. NAME OF HUSBAND OR WIFE Dorothea Wulkopf
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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 none	16. SOCIAL SECURITY NO. 494-05-2456	17. INFORMANT Address Mrs. Dorothea Wulkopf 4547 Claxton
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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) Bilateral Lobar Pneumonia		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the disease condition given in PART I (e.g., fall on steps while working at Kearney Corp. 4244 Sargey Ave., about 10:15 am., April 14, 1959)		18. 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 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.) fall on steps while working at Kearney Corp. 4244 Sargey Ave., about 10:15 am., April 14, 1959
20c. TIME OF INJURY Hour a.m. 10:15 Month, Day, Year 4 14 59	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.) 18 Factory
20f. CITY, TOWN, OR LOCATION St Louis Mo		COUNTY STATE

21. I attended the deceased from _____ and last saw her alive on _____
Death occurred at _____ **700 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Patric Taylor Cooney	(Degree title)	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 3.21.60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/22/60	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City, town, or county) St. Louis Co. Mo.

24. FUNERAL DIRECTOR JOHN STYGAR & SON 5541 Riverview Bl.	25. DATE RECD. BY LOCAL REG. MAR 21 1960	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjb

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 *JM Ruster*

Licensed Embalmer No. 3980

P. O. Address St Louis, Mo

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.