

FEDERAL BUREAU OF INVESTIGATION
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017754

FILED VS MAY 12 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1412

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST LOUIS</u>	a. STATE <u>MO</u>	b. COUNTY	admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHMOND HEIGHTS</u>	Length of stay in lb <u>DAYS</u>	c. CITY OR TOWN <u>ST LOUIS</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>2659 OREGON</u>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>HELEN</u>	Middle	Last <u>WOLKEN</u>	4. DATE OF DEATH	Month <u>APRIL</u>	Day <u>28</u>	Year <u>1960</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 23 1891</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE FAMILY</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>	Months	Days

13a. FATHER'S NAME <u>HENRY WOLKEN</u>	13b. MOTHER'S MAIDEN NAME <u>SANDERS</u>	14. NAME OF HUSBAND OR WIFE <u>H.B. WOLKEN (DECD)</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT Address <u>LESTER WOLKEN 2461 LOUIS</u>
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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) <u>Amyotrophic lateral sclerosis</u>	<u>3 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <u>Diabetes Mellitus</u>	<u>unknown</u>
DUE TO (c) <u>356.1</u>	

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 checked="" 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

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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Mar. 3, 1960 to Apr. 28, 1960 last saw her/him alive on Apr. 27, 1960
 Death occurred at 3:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>4445 a S. Grand Blvd.</u>	22c. DATE SIGNED <u>4.29.60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>APR 30 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER + PAUL CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
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24. GENERAL DIRECTOR ADDRESS <u>Thomas Kutis 2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>4-29-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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 Elena Province

Licensed Embalmer No. 3403

P. O. Address 2906 gra

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.