

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

-60-028948

FILED VS. JUL 22 1960

318

1003

6708

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b		c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital</i>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>4020 North 9th</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>J.</i> Last <i>Wolf</i>				4. DATE OF DEATH Month <i>July</i> Day <i>1</i> Year <i>1960</i>				
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>5-1-1883</i>	9. AGE (last birthday) <i>77</i>	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) <i>Chemical worker</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (City and state or country) <i>Austria</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>John Wolf</i>			13b. MOTHER'S MAIDEN NAME <i>Unknown</i>			14. NAME OF HUSBAND OR WIFE <i>Deceased</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>489-05-4564</i>		17. INFORMANT Address <i>Fred Wolf - 4020 North 9th</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Skull</i>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)							903.5 - 44	
DUE TO (c)								
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		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) <i>shuffled in fall in street in front of about 3900 No Broadway on or about June 28th 1960</i>						
20c. TIME OF INJURY Hour <i>6</i> a.m. <i>28</i> p.m. <i>60</i> Month, Day, Year <i>1960</i>		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.) <i>26 Street</i>		20f. CITY, TOWN OR LOCATION <i>St. Louis Mo</i>		COUNTY STATE
21. I attended the deceased from <i>120 P.</i> and last saw her/him alive on <i>120 P.</i> Death occurred at <i>120 P.</i> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Joseph D. Zimmerman Deputy Cor</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>7-2-60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>July 5, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>		23d. LOCATION (City, town, or county) <i>St. Louis Mo</i>				
24. FUNERAL DIRECTOR <i>Edw Koch + Son - 3516 S. 14th</i>			25. DATE RECD. BY LOCAL REG. <i>JUL 2 1960</i>		26. REGISTRAR'S SIGNATURE <i>Karl Smith, M.D.</i>			

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 *[Handwritten Signature]*

Licensed Embalmer No. 4329

P. O. Address *[Handwritten Address]*

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.