# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

Do not use this space.

18590

File No.

Registered No. 4957

**1. PLACE OF DEATH**

County

Township

City St. Louis City Hospital #2 (If not in hospital, street address) St.

Registration District No. 791

Primary Registration District No. 1003

Ward)

**2. FULL NAME** Katie Wolf

(a) Residence. No. 712 S. 18th St., 22 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| Female | Col. | Widowed |

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 15, 1863

| 7. AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 65 | 1 | 19 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Nil
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ill
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Edmond Harris

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED 19 Mary E. Starkloff
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 4, 1928

17. I HEREBY CERTIFY, That I attended deceased from 5/3, 1928, to 5/4, 1928, that I last saw he alive on 5/4, 1928, and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
9510
Infl. 903 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? Not known
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) L. C. Howell, M. D.

, 19 (Address) City Hosp. #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Olmstead Ill

DATE OF BURIAL 5-8-1928

20. UNDERTAKER Peoples Und. Co

ADDRESS 3100 Franklin

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.