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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

File No. 28485

Registered No. 7904

City St. Louis (No. City Hospital St. ..... Ward)

2. FULL NAME George B. Wolff

(a) Residence. No. Roch Hospital St., 1823 Ward. St. Louis Co. Mo
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12 - 1858

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
69	7	20.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Porter.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

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

PARENTS

10. NAME OF FATHER George Wolff.

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

12. MAIDEN NAME OF MOTHER Catherine Keith.

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

14. INFORMANT Hospital Information
(Address) City Hospital

15. FILED 1923 Max C Stahlberg
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 1 1928

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1928, to Aug 1, 1928, that I last saw him alive on Aug 1, 1928, and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. Myocarditis

93C

(duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 90B

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) R. Berg, M. D

8/1, 1928 (Address) City Hospital

*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: Mo. Crematory

DATE OF BURIAL: Aug 3 1928

20. UNDERTAKER: E. J. Schnur

ADDRESS: 3125 Lafayette W.

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.

Moeff.