

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

Do not use this space.

35922

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No. **10733**

Registered No. **10733**

St. Ward)

2. FULL NAME

(a) Residence. No. **3734 S. Bldg** St. **24** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **60** yrs. **0** mos. **0** 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)

Single

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

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

Oct 1 - 1864

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

45

0

30

8. OCCUPATION OF DECEASED

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

Lawyer 131 1077

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

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(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

10. NAME OF FATHER

Anton Wolff

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Caroline Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14. INFORMANT

(Address)

City Hospital

15. FILED

NOV - 1 1929

Max C. Stankley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 31 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 25 1929* to *Oct 31 1929* that I last saw him alive on *Oct 31 1929* and that death occurred, on the date stated above, at *4:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Genie arteriosclerosis
Chronic Interstitial Nephritis
Chr. Passive Congestion Spleen Liver & Left Lung (base)*

CONTRIBUTORY (SECONDARY) *Broncho Pneumonia Entire Rt. Lung.*

18. WHERE WAS DISEASE CONTRACTED

3734 So. Bldg

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY? *yes*

21. WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Deey Margulies, M. D.*

Address) *City Hosp*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

New St Marcus Nov 2 1929

20. UNDERTAKER

ADDRESS

Wacker Helderke 2331-5 Bldg

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.

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