

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

Do not use this space.

15813

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis,**

(No. **St Anns Maternity Hospital.** St. Ward)

File No.

Registered No. **4267**

2. FULL NAME

Robert J. Wolk,

(a) Residence. No. **4135 So. Grand Blvd.** St. **15** Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 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 **Single.**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 26, 1931.**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
11.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **None.**

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

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **St. Louis,** (STATE OR COUNTRY) **Mo. /**

10. NAME OF FATHER **William Wolk Jr.**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **St. Louis,** (STATE OR COUNTRY) **Mo.**

12. MAIDEN NAME OF MOTHER **Hildegard Albach.**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis,** (STATE OR COUNTRY) **Mo.**

14. INFORMANT **Mr. Wolk** (Address) **4135 So. Grand Blvd.**

15. FILED **1931** **Mar 27** **1931** **Mar 27** **1931** **Mar 27** **1931** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 18. DATE OF DEATH (MONTH, DAY AND YEAR) **Apr 7 1931**

17. I HEREBY CERTIFY, That I attended deceased from **Apr 5** 19**31**, to **Apr 7** 19**31**, that I last saw h. alive on **Apr 7** 19**31**, and that death occurred, on the date stated above, at **7:45** **PM** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia acute Primary 10 7 A 10 7 A (duration) yrs. mos. **5** ds.
CONTRIBUTORY Upper respiratory infection (SECONDARY) 10 7 A (duration) yrs. mos. **5** ds.

18. WHERE WAS DISEASE CONTRACTED **10 7 A** IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **Chest** (Signed) **Maurice Conway**, M. D. **Apr 8, 1931** (Address) **3730 Washington Av**

*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 **New Sq. Peter & Paul Cem.** DATE OF BURIAL **Apr. 8, 1931.**

20. UNDERTAKER **J. G. ...** ADDRESS **...**

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.

