

**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**

City *St. Louis* (No. *3650*)

City *St. Louis* St. *St. Louis* Ward *15*

File No. **22143**

Registered No. **5915**

**2. FULL NAME**

(a) Residence, No. *2910*  
(Usual place of abode)

*Mildred Dempe Wolf* (DEMPER WOLF)

Length of residence in city or town where death occurred *16 yrs. 10 mos. 2 ds.* How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *F* 4. COLOR OR RACE *W* 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) *Aug 11 - 1917*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<i>16</i>	<i>10</i>	<i>2</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *none*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Mo*

FATHER 13. NAME *Frank Dempe*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Mo*

MOTHER 15. MAIDEN NAME *Emma*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT (ADDRESS) *Ward Hospital*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Hope* DATE *6-16-34*

19. UNDERTAKER (ADDRESS) *Franklin and*

20. FILED *15* 19 *34* Registrar. *J. W. Redick*

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 13, 1934*

22. I HEREBY CERTIFY That I attended deceased from *6/3/34* to *6/13/34*  
I last saw him alive on *6/13/34* Death is said to have occurred on the date stated above, at *3:20* m.

The principal cause of death and related causes of importance were as follows:

*Acute nephritis*  
*acute myocarditis*  
*no other causes known*

Other contributory causes of importance:

*190*

Name of operation *none* Date of *6/3/34*

What test confirmed diagnosis? Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

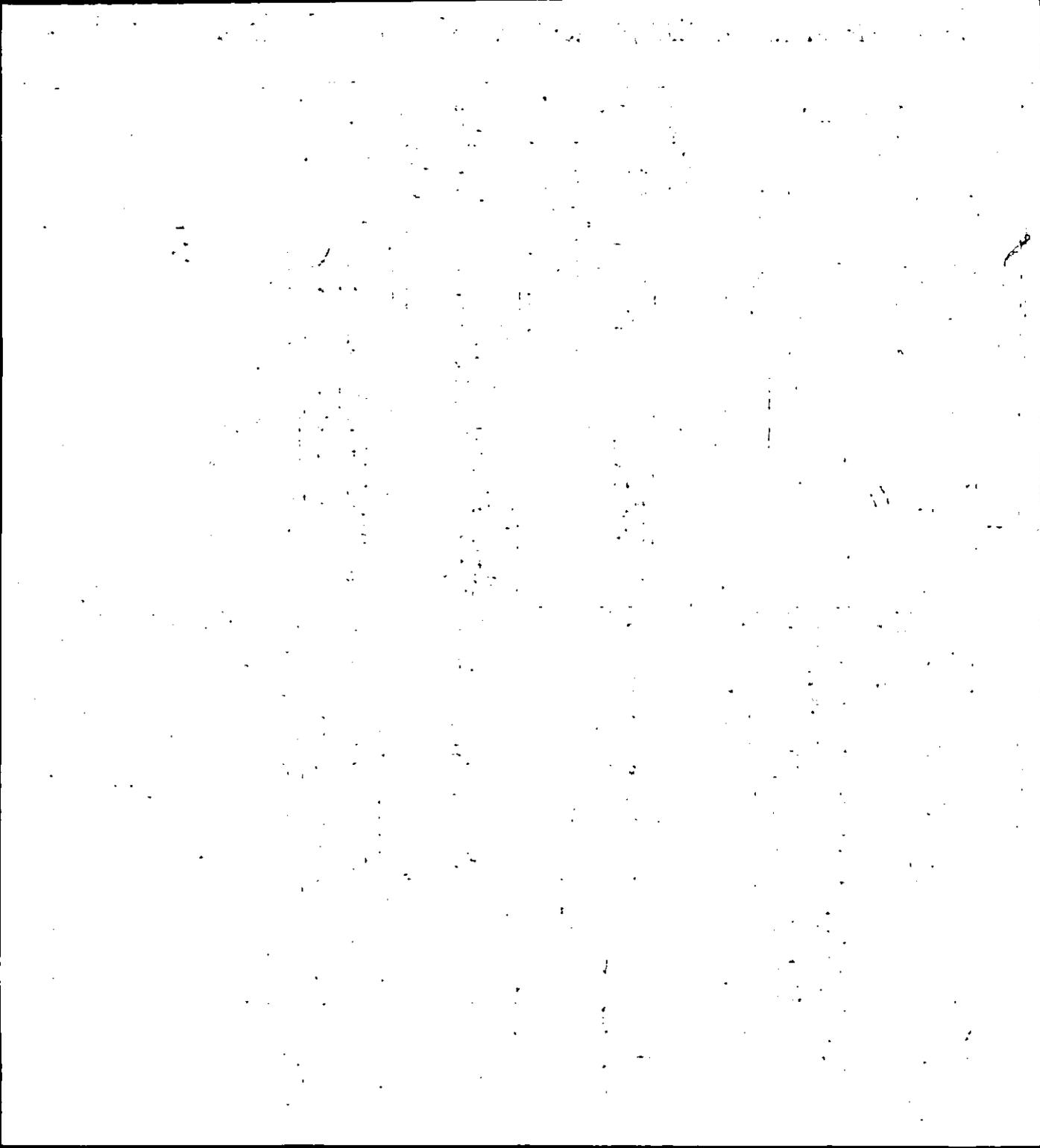
24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) *J. W. Redick* M. D.

(Address) *City, St. Louis*

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.



St Louis City

WASHINGTON 22143

5915

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Melmed Bernpfeil  
Who died at \_\_\_\_\_ on June 13-1934  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex F Color or race W Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years 16 Months 10 Days 20

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: acute nephritis - acute mastoiditis Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: Acute Nephritis Caused by Cholelithiasis media

Other contributory causes of importance: Cholelithiasis media

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician R. Bennett Kelly

Address of physician \_\_\_\_\_

Signature of Registrar J. J. Bredebeck Date filed 10-15-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 791 Very truly yours,

Primary Reg. Dist. No. 1003

E. T. McLaugh  
Special Agent,  
State Registrar

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ADMINISTRATIVE

5-22143

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