

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.

JUN 5 1936

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

Do not use this space.

20715

## 1. PLACE OF DEATH

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1008**  
City..... **St. Louis, Mo.** (No. **2025 A Russell Blvd.**)

File No. **4928**  
Registered No. .... St. .... Ward)

2. FULL NAME **Herman B. Wolken**

(a) Residence, No. **2025 A Russell Blvd.** St., **23** Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **67 yrs. 8 mos. 9 ds.** How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Minnie Wolken</b>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>Sept. 13, 1868</b>		
7. AGE	YEARS	MONTHS
	<b>67</b>	<b>87</b>
		<b>221</b>
	If LESS than 1 day, ..... hrs. or ..... min.	

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <b>Dairyman</b>
	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)..... <b>1920</b>
	11. Total time (years) spent in this occupation.....

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

FATHER 13. NAME **Herma. B. Wolken**

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

MOTHER 15. MAIDEN NAME **Mary Schimhoff**

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

17. INFORMANT (ADDRESS) **Minnie Wolken 2025 Russell Blvd.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Alton Ill.** DATE **May 6, 1936**

19. UNDERTAKER (ADDRESS) **Dr. E. Maynard 1926 Allen Ave.**

20. MAY 6 - 1936 **J. A. Bredeck** Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 4, 1936** 19

22. I HEREBY CERTIFY, That I attended deceased from **7:46 11**, 19**36**, to **my 4**, 19**36**.  
I last saw him alive on **my 4**, 19**36**. Death is said to have occurred on the date stated above, at **7 A.M.**  
The principal cause of death and related causes of importance were as follows:

Date of onset

**Coronary disease** Jan 1935

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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? **h**  
If so, specify.....

(Signed) **Frank R. ...** M. D.  
(Address) **3711 ...**

