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.

REC'D MAR 13 1939

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

791
1003

4985
Do not use this space.

1678

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. .....
(c) City St. Louis (d) Street No. City Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

410

2. PRINT FULL NAME Henry J. Rolf,
(a) Residence, No. 3838 Russell Blvd., St. 17
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Cora E. Rolf,

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Nov. 5, 1859

7. AGE: YEARS 79 | MONTHS 3 | DAYS 13 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Retired
9. Industry or business in which work was done, as saw mill, bank, etc.: laborer
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, Missouri

FATHER
13. NAME: Casper Rolf,
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany.

MOTHER
15. MAIDEN NAME: Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Mr. Irvin H. Rolf, 4001 Randall St.

18. BURIAL, ~~CREMATION OR REMOVAL~~
PLACE St. John's DATE Feb'y 22, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Wagoner Und. Co. 3621 Olive St.

20. FILED FEB 21 1939 J. F. Biedeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

NO ATTENDING PHYSICIAN

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 2/18/39, 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 3:35 P.M.
The principal cause of death and related causes of importance were as follows:

Date of onset

Concussion of the Brain; Fracture of Ribs; Laceration of left foot and left leg; Arterio Sclerosis; suffered when deceased fell over banister in his home 3838 Russell Blvd., on February 16th, 1939, at about 4:45 A.M.

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 2/16/, 19 39
Where did injury occur? St. Louis, Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. In Home
Manner of injury See Above
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Joseph M. Quinn, M.D.
(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Neville B. Frohwitter

Licensed Embalmer No. 3696

P. O. Address 3621 Olive St.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.