

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9300**

Registration District No. **791** Primary Registration District No. **1003** Registrar's No. **2783**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **City Hospital, #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 Days**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Rose Mary Wolpers**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **February 25 1940**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days **29** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business _____

12. Name **Bernard Wolper**

13. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Theresa Lyons**

15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bernard Wolper**

(b) Address **1512 near St. Louis ave.**

17. (a) **Burial** (b) Date thereof **3-26-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem**

18. (a) Signature of funeral director **H. J. Budesh**
(b) Address **1417 N. Market St.**

19. (a) **MAR 25 1940** (Date received local registrar)
J. J. Budesh (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis 26**
(If outside city or town limits, write "RURAL")
(d) Street No. **1512 near St. Louis ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **24**,
year **1940** hour **9:55** minute **A.** M.

21. I hereby certify that I attended the deceased from **March 20, 1940**, to **March 25, 1940**;
that I last saw her alive on **March 25, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Lung Abscess Empyema** Duration **7-10d.**

Due to **Staph Aureus.**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **as above**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **C. E. Muhlestein** (Date of other) _____
Address **1515 Lafayette,** Date signed **3/25/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

110

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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St. Louis Ave

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9360
Registrar's No. 2783-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 79pc370

Primary Registration District No. 1003

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Rose M. Holgers-

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced P-

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 29- If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-9-40 (b) J. A. Bedrak (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month Mar. day 24 - 40
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Lung abscess - Staphylococcus aureus
Empyema
Due to unknown
Due to Staph aureus
Other conditions _____
(Include pregnancy within 3 months of death)

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at _____ (Specify type of place) (e) Means of injury _____

23. Signature P. E. Nishleman (Mr. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

