

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **284**

Primary Registration District No. **115**

1. PLACE OF DEATH:

(a) County **SAINT LOUIS**
(b) City or town **UNIVERSITY CITY.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6402 Enright Ave. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **ANNA MAUTZ WOOLGER** **1276**
8. (b) If veteran, name war **none.** 3. (c) Social Security No. **none.**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**
6. (b) Name of husband or wife **E. M. WOOLGER.** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **APRIL 10 1868.**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	3	22	hr. _____ min.

9. Birthplace **GREEN CASTLE OHIO**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business _____
MOTHER FATHER { 12. Name **GOTTLIEB MAUTZ.**
13. Birthplace **GERMANY** (State or foreign country)
14. Maiden name **FRANCES FFRINDER**
15. Birthplace **WURTENBERG GERMANY** (State or foreign country)

16. (a) Informant **AGNES W. MILLIGAN**
(b) Address **7709 SHIRLEY DRIVE**

17. (a) **BURIAL** (b) Date thereof **AUG. 5 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **OAK GROVE CEMETERY**

18. (c) Signature of funeral director **C. R. LUPTON SONS**
(b) Address **7233 DELMAR BLVD.**

19. (a) **AUG 3- 1940** (b) **A. R. Miller**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **ILLINOIS** (b) County _____
(c) City or town **HIGHLAND PARK**
(If outside city or town limits, write "RURAL")
(d) Street No. **366 RAVINE DRIVE.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **aug** day **1st.**
year **1940** hour **10** minute **30** M.

21. I hereby certify that I attended the deceased from _____, 19**40**, to _____, 19**40**.
that I last saw h. **alive** on **aug 1**, 19**40**:
and that death occurred on the date and hour stated above.

Immediate cause of death
chronic myocarditis
cardiac failure. **years.**

Due to **93c**

Other conditions **hypertension.**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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)
(a) Means of injury _____

23. Signature **R H milligan** (M. D. or other) _____
Address **7475 Stanford** Date signed **8-2-40**

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

10-12 a.m.
92-9030
3770 Washington Ave
St. Louis, Mo

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 Clarence H. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis, Mo

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.