

No. 2
11-10-39
5-17-39
I 21

JAN 15 1940 791

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **9932**

1. PLACE OF DEATH

(a) County **30**

(b) City or town **St. Louis**

(c) Name of hospital or institution: **Carroll City Hospital**
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** County _____

(c) City or town **St. Louis** **23**
(If outside city or town limits, write "RURAL")

(d) Street No. **1420th St** **13**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

In this community _____ years, months or days

3. (a) PRINT FULL NAME **Peter Wolf**

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

4. Sex **male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Widowed**

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

7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: **68** Years Months Days If less than one day
hr. min.

9. Birthplace **Mo** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Painter** **9**

11. Industry or business **Unknown** **9**

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 **Willard Lee - P.D.**

(b) Address **4225th Red Bank**

17. (a) _____ **(b) Date thereof** **11-26-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington B**

18. (a) Signature of funeral director **W. Richter**
(b) Address **W. Richter 3129 Park**

19. DEC 4 1940 **(b) J. H. Bruback**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **11** day **18**
year **1940** hour **12** minute **30** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy**

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

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) **5**
(e) Means of injury _____

23. Signature **J. H. Bruback** (M. D. or other) _____
Address **Adelphi** **Date signed** _____

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.