

MAY 12 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15659

State File No. _____

Registration District No. 257

Primary Registration District No. 3036

Registrar's No. 68

1. PLACE OF DEATH:
(a) County ST. CHARLES
(b) City or town ST. CHARLES
(c) Name of hospital or institution: ST. JOSEPH'S HOSP. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County WARREN
(c) City or town WARRENTON
(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.

3. (a) PRINT FULL NAME WILLIAM WOLF

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month April day 8
year 1941 hour 1 minute P. M.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

21. I hereby certify that I attended the deceased from March 25, 1941, to April 8, 1941;
that I last saw him alive on April 8, 1941;
and that death occurred on the date and hour stated above.

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

Immediate cause of death Cerebral Hemorrhage Duration 1 day

7. Birth date of deceased Nov. 18, 1867
(Month) (Day) (Year)

Due to Hypertension
essential hypertensive

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>4</u>	<u>20</u>	hr. _____ min. _____

Due to Prostatic Obstruction

9. Birthplace COTTLEVILLE MO. O
(City, town, or county) (State or foreign country)

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

10. Usual occupation LABORER

Major findings: Hypertrophy Prostate
Complete Retention
Of operations _____
Of autopsy _____

11. Industry or business _____

MOTHER FATHER { 12. Name HENRY WOLF
13. Birthplace unknown 1 9
(City, town, or county) (State or foreign country)

14. Maiden name CAROLINE HASEL
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant MRS. FRANK BOETTLER
(b) Address WARRENTON, MO.

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

17. (a) COTTLEVILLE, MO. (b) Date thereof APR 10, 1941
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation COTTLEVILLE, MO.

23. Signature Vincent A. Schermer (M. D. or other) _____
Address Warrenton, Mo. Date signed 4/8/41

18. (a) Signature of funeral director F. W. Melberg & Co.
(b) Address Warrenton, Mo.

19. (a) 4-8-41 (b) Clarence S. Kiser
(Date received local registrar) (Registrar's signature)

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

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

Signed John F. Meburg
Licensed Embalmer No. 3897
P. O. Address Warrenton, Or

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, fact should be so stated above.

STATE V BKS.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-659

Registration District No. 752

Primary Registration District No. 3036

Registrar's No.

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Wm Wolf
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S
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 73 Months 4 Days 20 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 _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 8
year 1941 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 _____ Duration _____

Cerebral Hemorrhage

Due to Hypertension
Chronic nephritis

Due to Prostatic Obstruction

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

Major findings: Hypertrophy prostate
Of operations: Complete prostatectomy
Of autopsy: April 7-1941

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) (e) Means of injury _____

23. Signature Wm A. Schmidt (M. D. or other) MD
Address St Charles, Mo. Date signed 6/24/41

SUPPLEMENTARY

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

MOTHER FATHER

S-15659