

FILED FEB 4 1943

Registration District No. **818**

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: **De Paul Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **24 days**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Albert Wulf**

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

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Anna Wulf** 6. (c) Age of husband or wife if alive **38 years**
7. Birth date of deceased **March 25 1901**
(Month) (Day) (Year)

8. AGE: Years **41** Months **10** Days **4** If less than one day hr. min.

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

10. Usual occupation **mailman**

11. Industry or business **U.S. Post Office**

MOTHER FATHER { 12. Name **August Wulf**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Berger**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Anna Wulf**
(b) Address **4019 Grove st**

17. (a) **Burial** (b) Date thereof **Feb-1-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Old St. Peter & Paul Cem**

18. (a) Signature of funeral director **A. Krou R.O. 60**
(b) Address **2707 N. Grand Blvd**
19. (a) **JAN 31 1943** (b) **J.F. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **100**
(c) City or town **St. Louis** (d) Street No. **4019 Grove St**
(If outside city or town limits, write "RURAL") (If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **29**
year **1943** hour **1** minute **40** a. m.

21. I hereby certify that I attended the deceased from **1-5-43** to **1-29-43**
that I last saw him alive on **1-28-43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Perforated** Duration **1-5-43**

Due to **Perforated ulcer**
Due to **Beriberi**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Perforated ulcer + general beriberi**
Of operations _____
Of autopsy **not done**

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 **J. Whisnand** (M. D. or other) _____
Address **4952 Maryland** Date signed **1-29-43**

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 Paul F. Knollenberg
Licensed Embalmer No. 2631
P. O. Address 2707 N Grand

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.