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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 6 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8415

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 534

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Jefferson Barracks, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans' Administration Facility 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Adm. Feb. 17, 1944 (Specify whether
In this community -- years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Missouri (b) County -- 17
(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")
(d) Street No. 2701 Park Ave.
(If rural, give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME VOLKER, Eddie
3. (b) If veteran, name war W.W. #1
3. (c) Social Security No. Yes, not rem.
4. Sex Male
5. Color or race White 0
6. (a) Single, widowed, married, divorced Divorced 3
6. (b) Name of husband or wife -- Clara
6. (c) Age of husband or wife if alive Unknown years
7. Birth date of deceased March (Month) 26 (Day) 1895 (Year)
8. AGE: Years 48 Months 11 Days 2 If less than one day hr. min.
9. Birthplace St. Louis, Missouri 0 (City, town, or county) (State or foreign country)
10. Usual occupation R.R. Switchman.
11. Industry or business --
FATHER 12. Name Charlie Volker.
13. Birthplace Unknown (City, town, or county) Illinois 1 (State or foreign country)
MOTHER 14. Maiden name M. Effie Hopkins.
15. Birthplace Unknown (City, town, or county) Missouri 0 (State or foreign country)
16. (a) Informant M. Schilling Cl. Clk.
(b) Address Vets. Adm. Fac., Jeff. Brks., Mo.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH-2-44 (Month) (Day) (Year)
(c) Place: burial or cremation NATIONAL CEM. Jefferson Bks. Mo.
18. (a) Signature of funeral director E. J. Schmurd
(b) Address 3125 Lafayette Av.
19. (a) MAR 1 1944 (Date received local registrar) T. C. G. McGavran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 28th year 1944 hour 1:00 PM. minute M.
21. I hereby certify that I attended the deceased from February 17, 1944 to February 28, 1944 that I last saw him alive on February 28, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death METABOLIC HEART DISEASE, DUE TO AVITAMINOSIS (VITAMIN B. DEFICIENCY) WITH CARDIAC ENLARGEMENT, MYOCARDIAL DAMAGE AND INSUFFICIENCY. — Duration: UNKNOWN

Other conditions DRUG ADDICTION (MORPHINISM) (Include pregnancy within 3 months of death) — Duration: UNKNOWN.
ALCOHOLISM, CHRONIC.

Major findings:
Of operations No operation 68
Of autopsy No autopsy

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) No
(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? (Specify type of place)
While at work? Means of injury 0

23. Signature L. M. COCHRAN, M.D., (M. D. or other)
Address Chief Medical Officer Date signed 2-28-44

(Licensed Embalmer's Statement on Reverse Side)

MAR 10 194

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 Jos B Vollmer

Licensed Embalmer No. 41014

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, fact should be so stated above.