

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County **St. Louis Mo**  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Lutheran Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **78 weeks**  
(Specify whether **78 years**)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3645 De Troy**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **EMIL J. Wolzendorf**  
3. (b) If veteran, name war **WW**  
3. (c) Social Security No. **220**

MEDICAL CERTIFICATION  
23. DATE OF DEATH: Month **June** day **15**  
year **1944** hour **7** minute **0** M.  
21. I hereby certify that I attended the deceased from **May 27**, 1944 to **June 15**, 1944  
that I last saw him alive on **June 15**, 1944  
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Oct 17 1865**  
(Month) (Day) (Year)

Immediate cause of death **Cerebral apoplexy** Duration **18 days**

8. AGE: Years **78** Months **7** Days **26** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to **Cerebral Arterio Sclerosis** **Several years**

9. Birthplace **St. Louis Mo** (City, town, or county) (State or foreign country)  
10. Usual occupation **Retiree**

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
12. Name **Ferdinand Wolzendorf**  
13. Birthplace **Austria** (City, town, or county) (State or foreign country)  
14. Maiden name **Therese**  
15. Birthplace **Bernsmy** (City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_

16. (a) Informant **Mrs. Henretta Wilbert**  
(b) Address **3645 De Troy St**  
17. (a) **Cremation** (b) Date thereof **6/19/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Muenich Crematory**  
18. (a) Signature of funeral director **J. F. Nowak**  
(b) Address **4212 St. Louis Ave**  
19. (a) **JUN 17 1944** (b) **J. F. Breese**  
(Date received local registrar) (Registrar's signature)

23. Signature **St. Louis Schuchat** (M. D. or other) \_\_\_\_\_  
Address **2200 Chittenden** Date signed **6-16-44**

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

MOTHER FATHER

DEC 15 1944

**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 A. Howard*

Licensed Embalmer No.....

4139

P. O. Address.....

4212 St LOUIS AV

**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.**