

FILED SEP 29 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2256

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 days
(Specify whether
In this community 45 years
years, months or days)

3. (a) PRINT FULL NAME Fred Wolke

3. (b) If veteran, name war ? 3. (c) Social Security No. 48801-9284

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 December 9 1890
(Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days 10 If less than one day hr. _____ min. _____

9. Birthplace St. Charles Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Elevator operator

11. Industry or business

MOTHER FATHER { 12. Name Ferdinand Wolke
13. Birthplace ? Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mary Bock
15. Birthplace ? Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Record
(b) Address Koch Hospital

17. (a) Burial (b) Date thereof 9/24/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son
(b) Address 2161 East Fair Ave

19. (a) 9-24-45 (b) E. B. M. Barron, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 100
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5230 N. Broadway 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19
year 1945 hour 11:25 minute P. M.

21. I hereby certify that I attended the deceased from August 31 1945, to Sept. 19 1945, that I last saw him alive on Sept. 19 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cor Pulmonale
Emphysema
Chronic failure
Due to 113
Other conditions (Include pregnancy within 3 months of death) _____

Duration
?
?

Major findings:
Of operations _____
Of autopsy Cor Pulmonale

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) (c) Means of injury _____
23. Signature R. Englemann, M.D. (M.D. or other)
Address Koch Hospital Date signed 9/21/45

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

76
0
0

OCT 19 1945

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 *William G. Bushby*

Licensed Embalmer No. *2110*

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.