

FILED JAN 23 1947  
Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 287

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
CITY HOSPITAL  
(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 HUGO WOLF  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced ?  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased: FEB. 19  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
abt 70 - - - - - hr. min.

9. Birthplace..... (City, town, or county) Germany (State or foreign country)

10. Usual occupation N/A

MOTHER FATHER { 11. Industry or business

12. Name John WOLF  
13. Birthplace..... (City, town, or county) Germany (State or foreign country)  
14. Maiden name UNK.  
15. Birthplace..... (City, town, or county) Germany (State or foreign country)

16. (a) Informant Mrs. C. Doolittle  
(b) Address Joplin Mo.

17. (a) CREMATION (b) Date thereof Jan 10 - 47  
(Method, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE CREMATORY

18. (a) Signature of funeral director E. J. Schurr

(b) Address 3125 Lafayette Av.

19. (a) JAN 10 1947 (b) J. Schurr  
(Date received local registrar) (Registrar's signature)

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. 100 S. 4th St. (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8  
year 1947 hour 11 minute 30 A. 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 Coronary Occlusion Duration 1 hr

Intermittent

Due to.....

Due to.....

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

Major findings:  
Of operations.....  
Of 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).....  
(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?..... (c) Means of injury Car

23. Signature Patrick E. Taylor M.D. or other MD  
Address 1300 Clark Date signed 1-10-47

APR 3 1992

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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, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Rex E. Campbell*

Licensed Embalmer No.....

P. O. Address.....

*23881  
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.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... **ST. LOUIS**  
(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

Hugo wopf

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.....

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

7. Birth date of deceased Feb (Month) 1947 (Day) 1947 (Year)

8. AGE: att 70 Years Months Days 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.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) J.F. Brebeck (Registrar's Signature) 1947

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..... Day.....  
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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

Due to.....  
Due to.....

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

Major findings:  
Of operations.....  
Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

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(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..... (M. D. or other).....  
Address..... Date signed.....

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SUPPLEMENTARY

