

FILED MAY 22 1947

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4806**

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:  
St. John's Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 Weeks  
(Specify whether in this community  
7 Months 22 Days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5418 Goethe  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Robert J. Volkening

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 Single

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

7. Birth date of deceased September 19 1946  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	--	7	22	hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name W. Roland Volkening

13. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Claudine Werner

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

16. (a) Informant W. Roland Volkening

(b) Address 5418 Goethe

17. (a) Burial (b) Date thereof May 13 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery BEIDERWIEDEN F. H. INC.

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address 1936 St. Louis Ave.

19. (a) MAY 13 1947 (b) J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11  
 year 1947 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from Apr 3  
1947 to May 11 1947

that I last saw him alive on May 11 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Enterocolitis Duration 1 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 11/9  
(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? \_\_\_\_\_ (e) Means of injury 0

23. Signature PJ Munson (M. D. or other) \_\_\_\_\_

Address Mo. State Bldg Date signed May 12-47

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

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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.....

*Neal LeRoux*

Licensed Embalmer No. *4114*

P. O. Address.....

*1936 St. Louis Ave*

**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.**