

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22783**

FILED JUL 12 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6339**

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..... (Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Josephine Wolf**

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Harry Wolf** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **1 8 1888**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 5 23 hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business.....

12. Name **Andrew Freeman**
13. Birthplace **unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Barbara unknown**
15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Gurman Wolf**
(b) Address **3029 Kemp Dr.**

17. (a) **burial** (b) Date thereof **7/3/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **Drehmann-Harral**
(b) Address **JUL 3 1905 Union Blvd.**

19. (a) **JUL 3** (b) **J. J. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **STL**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **26 2111 Salisbury Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1**
year **1947** hour **6:45** minute **A.M.**

21. I hereby certify that I attended the deceased from **5/31/47**
19..... to **7/1/47**, 19.....
that I last saw her alive on **6/30/47**, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinomatosis of esophagus & block of esophagus**
Due to **Carcinoma of Breast** **5 yrs ago**

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

Major findings:
Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline the cause of 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..... (Specify type of work) Means of injury.....
23. Signature **Shubert** (M. D. or other) **MD**
Address **671 E. 11th St. St. Louis** Date signed **7/1/47**

Webster Bros, Mo.

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

MOTHER FATHER

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.....

Albert R. Thompson Jr

Licensed Embalmer No.....

4237

P. O. Address.....

St. Louis

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.