. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED OCT 13 1947

Registration District No. 13 947

Primary Registration District No. 6076

State File No. 33363

Registrar's No. 2034

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Pine Lawn
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Shamrock Rest Home, 3709 Manola 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7½ months (Specify whether

In this community ? years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 5043a Wells Ave. 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Lillie May Wollberg

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 2

6. (b) Name of husband or wife Robert Wollberg

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

7. Birth date of deceased August 7, 1881.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	66	1	23	hr. min.

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

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Wilfred Wollberg
(b) Address 5043a Wells Ave.

17. (a) Burial (b) Date thereof 10/2/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethany Cemetery

18. (a) Signature of funeral director Calvin F. Feutz
(b) Address 4828 Natural Bridge Blvd.

19. (a) 10-2-47 (b) Cecil A. Wolf MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 30
year 1947 hour 12:45 minute A. M.

21. I hereby certify that I attended the deceased from Feb 11, 1947, to Sept 30, 1947; that I last saw her alive on Sept 29, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	4 days
Due to Hypertensive & Arterio-sclerotic Cardio-Vascular-Renal disease	2 yrs
Due to 131a	
Other conditions (1) Blind (2) Uremia (3) Right hemiplegia (8 months) (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (e) Means of injury -0

23. Signature Lewis Littmann (M. D. or other) MD

Address 8231 Clayton Rd Date signed 9/30/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Pr 31 Clayton Cem

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 John A. Mlinar

Licensed Embalmer No. 4186

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.