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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAR 25 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10862

Primary Registration District No. 1003

Registrar's No. 2535

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 36

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

(d) Street No. NR
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Viola F. Wurmb

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Robert O Wurmb

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased February (Month) 22 (Day) 1880 (Year)

8. AGE: Years 68 Months 0 Days 21 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business At Home

MOTHER FATHER

12. Name Benjamin Dunivin

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

14. Maiden name Clara Burton

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

16. (a) Informant Robert O Wurmb

(b) Address St. Clair, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/48 (Month) (Day) (Year)

(c) Place: burial or cremation St. Clair, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.,

19. (a) MAR 14 1948 (Date received local registrar) (b) J.F. Bredrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13 year 1948 hour 12 minute 28 A.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;

that I last saw h alive on , 19 ;

and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Fracture of Right Femur suffered when deceased fell in the home

Due to Cerebral hemorrhage

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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

23. Signature (M.D. or other)

Address Date signed 3/14/48

(Licensed Embalmer's Statement on Reverse Side)

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

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 Henry W. Brammer

Licensed Embalmer No. 4200

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.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5535

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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Viola F Wurmb

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb (Month) 22 (Day) 1880 (Year)

8. AGE: Years 68 Months 0 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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) 3-14-1948 (Date received local registrar) (b) J F Breneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 13 year 1948 hour 6 minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h 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.

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

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

SUPPLEMENTARY

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