

STANDARD CERTIFICATE OF DEATH

State File No. 3181

FILED JAN 26 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 457

2009  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY 212	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Desloge Hospital		d. STREET ADDRESS (If rural, give location) 3853 McKee	
3. NAME OF DECEASED (Type or Print) a. (First) Fred b. (Middle) A. c. (Last) Wollschlaeger		4. DATE OF DEATH (Month) (Day) (Year) 1/13/50	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct 5 1866
9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saloon keeper	11. BIRTHPLACE (State or foreign country) St. Louis
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saloon keeper		10b. KIND OF BUSINESS OR INDUSTRY retired	12. CITIZEN OF WHAT COUNTRY? D
13a. FATHER'S NAME Frederick Wollschlaeger		13b. MOTHER'S MARDEN NAME Maryland Schall	
14. NAME OF HUSBAND OR WIFE Louise		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no or unknown) no	
16. SOCIAL SECURITY NO. 491-149364		17. INFORMANT'S SIGNATURE OR NAME Mrs. F. Wollschlaeger	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage from intestinal tract ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of rectum DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 1 week	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 154X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1/10, 1950, to 1/13, 1950, that I last saw the deceased alive on 1/12, 1950, and that death occurred at 12:13 a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Theoph. Kussella, D.M.S.		23b. ADDRESS 3720 Washington	23c. DATE SIGNED 1/14/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/16/50	24c. NAME OF CEMETERY OR CREMATORY Lena Cemetery	24d. LOCATION (City, town, or county) (State) Kentzville Mo.
DATE REC'D BY LOCAL REG. JAN 16 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. A. Howard 1619 So. Grand	

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Gas A. Howard

Licensed Embalmer No. 4139

P. O. Address 16195 Grand Blvd

**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.