

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30556**
Registrar's No. **7255**

FILED AUG 20 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 3 days	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 22 1523 Kealty Lane	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		4. DATE OF DEATH (Month) (Day) (Year) July 24, 1953.	
3. NAME OF DECEASED (Type or Print) a. (First) Samuel	b. (Middle) J.	c. (Last) Wolf	
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH January 8, 1876
9. AGE (in years last birthday) 77		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Shoe Worker	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri. 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Valentine Wolf	13b. MOTHER'S MAIDEN NAME Amelia Harris
14. NAME OF HUSBAND OR WIFE Augusta Wolf		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch or dates of service) no	16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Mrs. Augusta Wolf		ADDRESS 1523 Kealty Lane	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Coronary Occlusion Arteriosclerotic Coronary Artery Disease Antecedent Causes Myocardial conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Branchiopneumonia Fracture of 8th rib		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH Immediate 4 yrs. 5 days 5 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	21a. ACCIDENT (Specify) Fell in bathroom		
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis 4201 Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 21 1953 7 AM	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? (He) slipped in bathroom & struck tub.
22. I hereby certify that I attended the deceased from 11/20, 1948 , to 7/24, 1953 , that I last saw the deceased alive on 7/24, 1953 , and that death occurred at 4:00 Pm. , from the causes and on the date stated above.			
23a. SIGNATURE Math Hermann M.D.		23b. ADDRESS 4020 N. Florissant	
23c. DATE SIGNED 7/25/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-27-53	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri.
25. DATE RECD BY LOCAL REG. 9/11 27 1953	25. REGISTRAR'S SIGNATURE J. Cal Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math Hermann & Son, Inc. 2161 E. Fair Ave.	

WRITE PLAINLY - USING INK

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 _____

W. W. Natz

Licensed Embalmer No. _____

3737

P. O. Address _____

St Louis Mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.