

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44129

STATE FILE NUMBER

FILED DEC 18 1956

318

1003

10989

Registration District No. 318 Primary Registration District No. 1003 Registrar 10989

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3174 OREGON</u>			Length of stay in 15 <u>224</u> ⁹ <u>STREET</u> ADDRESS <u>3174 OREGON</u>		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JACOB H. WOLF</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 16 1868</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u>5</u> Min. <u>A</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>
13. FATHER'S NAME <u>LOUIS WOLF</u>				14. MOTHER'S MAIDEN NAME <u>EMMA KIEFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>LILLIE WOLF 3174 OREGON</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Terminal Pneumonia</u> <u>2 days</u>	
						DUE TO (c) <u>Pernicious Anaemia</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour <u>11:30</u> Month <u>Aug</u> Day <u>1949</u> Year <u>1949</u> a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Aug 1949</u> to <u>11/28/56</u> and last saw ^{her} him alive on <u>11/27/56</u> Death occurred at <u>11:30 AM</u> on <u>11/28/56</u> date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. M. Greub M.D.</u> (Dee or title)				22b. ADDRESS <u>3402 California St. Louis</u>		22c. DATE SIGNED <u>11/30/56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>DEC. 1, 1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HIRAM CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>		
24. FUNERAL DIRECTOR <u>Thomas Kutas 2906 Gravois</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>DEC 1 1956</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, welfare, public service

100-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms which be listed. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

4-5 PM and 7 to 8³⁰ PM
Thursday

Pr 2-3860
3-5 PM } Fri
7-9 PM }

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
James E. White

Licensed Embalmer No. 43

P. O. Address 2906

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.