THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 17 1957

STATE FILE NUMBER 34334

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8474

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Walton Nursing Home 4527 Forest Pk Bl — Length of stay in Institution 37 — Length of stay in this place 217
d. STREET ADDRESS (If outside, give location) 4146 A. Russell Blvd. — Reside on Farm Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle Last WOLF

4. DATE OF DEATH Month 9 Day 9 Year '57

5. SEX Female 1
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH 2/13/'74
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Czechoslovakia 4
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ? SLUKA
14. MOTHER'S MAIDEN NAME ? Koznar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ------
16. SOCIAL SECURITY NO.
17. INFORMANT Address Thomas Wolf-4146 A. Russell Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — 5 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Gangrene of left foot — 2 yrs
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 422.2

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Sept 5 57, to Sept 9, 57 and last saw her/him alive on Sept 5, 57
Death occurred at 6:30 A.M. 6:38 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) O. D. Meyer M.D. O. D. Meyer M.D.
22b. ADDRESS 6029 S. Kingshighway
22c. DATE SIGNED Sept 10

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 9/11/'57
23c. NAME OF CEMETERY OR CREMATORY Sun-set Cem.
23d. LOCATION (City, town, or county) St. Louis County, Mo. (State) 57

24. FUNERAL DIRECTOR MOYDELL FUNERAL HOME — ADDRESS 1926 ALLEN
25. DATE RECD. BY LOCAL REG. SEP 10 '57
26. REGISTRAR'S SIGNATURE J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Self, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Reinhold K. Lohman

Licensed Embalmer No. 3

P. O. Address St Louis

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.