

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42806

STATE FILE NUMBER

FILED NOV 21 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10943

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>ST LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) <b>HOSPITAL ST. LOUIS CITY HOSP #1</b>			Length of stay in 1b		STREET ADDRESS <b>1260 So. Vandeventer</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLARD</b> Middle <b>M.</b> Last <b>Wolfe</b>				4. DATE OF DEATH Month <b>11</b> Day <b>13</b> Year <b>57</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 29, 1895</b>		9. AGE (In years last birthday) <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		11. BIRTHPLACE (City and state or country) <b>St. James, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Jacob Wolfe</b>			13b. MOTHER'S MAIDEN NAME <b>Parazetta Pryor</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>William Wolfe, Robertson, Mo.</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE FROM DUODENAL ULCER</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>ACUTE PANCREATITIS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>541.0</b>								INTERVAL BETWEEN ONSET AND DEATH	
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 _____ a.m. _____ p.m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>St. James, Mo.</b>			COUNTY _____ STATE _____			
21. I attended the deceased from <b>11-7-57</b> to <b>11-13-57</b> and last saw her alive on <b>11-13-57</b> Death occurred at <b>6:15</b> P. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>H. James Solomon, M.D.</b>				22b. ADDRESS <b>1515 LAFAYETTE</b>		22c. DATE SIGNED <b>NOV 15 57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11-11-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) (State) <b>St. James, Mo.</b>			
24. FUNERAL DIRECTOR <b>Albert H. Hoppe 4700 Washington, Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 15 57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith mo</b> <i>mjs</i>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed *Robert M. Murray*  
Licensed Embalmer No. *3749*  
P. O. Address *St. Louis, Mo*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.