

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 784 Primary Registration District No. 106 Registrar's No. 1852

1. PLACE OF DEATH

(a) County St. Louis
(b) City or town Kirkswood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Base Crest Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
(Specify whether years, months or days) 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Ferdinand Wunderlich

3. (b) If veteran, name war no 3. (c) Social Security No. None

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife Ollie Wunderlich 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased March 15 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 7 6 hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Gen. Laborer

12. Name Ferd. Wunderlich

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Chas Wunderlich

(b) Address Pomper Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/39
(Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Mo

18. (a) Signature of funeral director Joe J. Fisher

(b) Address St. Louis Mo

19. (a) OCT 22 1939 (b) W.R. Meyer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 21
year 1939 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from 10/20/39, 19____, to 10/21, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death acute cardiac dilatation Duration 1 day

Due to chronic myocarditis 5 yrs

Due to _____

Other conditions bronchial asthma 7 weeks
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 93

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. H. Hedie (M. D. or other) _____

Address Kirkwood Mo Date signed 10/21/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Joe L. Sheehy*
Licensed Embalmer No. *3008*
P. O. Address *Pacific, 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 this body is not embalmed, above space should be left blank.