

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 17 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **6274**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(c) Name of hospital or institution:
St. Louis City Hospital
(d) Length of stay: In hospital or institution **9 Days**
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **4531a Alaska Ave.**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Anton Wadas**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **490-20-7029**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Josephine Wadas** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **January 2, 1879**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 6 6 hr. _____ min.

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

10. Usual occupation **Watchman**

11. Industry or business _____

12. Name **Don't Know**

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

14. Maiden name **Don't Know**

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

16. (a) Informant **Mrs. Josephine Wadas**
(b) Address **4531 Alaska Ave.**

17. (a) **Burial** (b) Date thereof **July 12, 1943**
(c) Place: burial or cremation **SS Peter and Paul (old)**

18. (a) Signature of funeral director **Weick Bros.**
(b) Address **2201 S. Grand Bl.**

19. (a) **J. F. Brulech**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8**, year **1943** hour **6:45** minute _____ P. M.

21. I hereby certify that I attended the deceased from **June 30**, 19**43**, to **July 8**, 19**43**
that I last saw him alive on **July 8**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic heart disease**

Due to _____
Due to _____

Other conditions **Pulmonary embolism**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **Refused**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(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 **Ray J. [unclear]** (M.D. or other) **not**
Address **1515 Lafayette Avenue** Date signed **7/9/43**

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

MOTHER FATHER

Duration
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

Mary C. Stewart

Licensed Embalmer No. 3722

P. O. Address 412 Duchouquette St.

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, fact should be so stated above.