

FILED JAN 5 1945

State File No. \_\_\_\_\_

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11175

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital - Max U. Starkloff Memorial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days (Specify whether  
in this community 12 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 819 Market St. (If rural, give location)  
(e) Citizen of foreign country? yes (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mack Waddell

3. (b) If veteran, name war unk 3. (c) Social Security No. unk

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Feb. 28th ?? (Month) (Day) (Year)

8. AGE: Years abt - 81 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation nil

11. Industry or business \_\_\_\_\_

12. Name Samuel

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

14. Maiden name Sarah

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Anatomical Board Date thereof 12-28-44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) DEC 29 1944 (Date received local registrar) J. F. Bredel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 14th year 1944 hour 10:30 minute \_\_\_\_\_ P. \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from 12/11/44 to Dec. 14th, 1944, and that death occurred on the date and hour stated above.

that I last saw h. im alive on Dec. 14th, 1944.  
Immediate cause of death arteriosclerotic Heart Disease Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_ (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 Herbert C. Fritz (M. D. or other) \_\_\_\_\_

Address 1515 Lafayette Date signed 12/14/44

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

---

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**