

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

FILED OCT 23 1948

Registration District No. **377**

Primary Registration District No. **3063**

1. PLACE OF DEATH:

(a) County Saint Louis

(b) City or town Clayton, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Saint Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Wickliffe G. Staten

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Marie Staten nee Laskowitz

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased: January 17th, 1889
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>8</u>	<u>2</u> hr. min.

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

10. Usual occupation Insurance Agent

11. Industry or business Metropolitan Life Insurance Co.

12. Name Joseph Taylor Staten

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

14. Maiden name UNKNOWN

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

16. (a) Informant Mrs. Marie Staten

(b) Address 4038 Green Lea Place

17. (a) Burial (b) Date thereof 9/22/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Calvin F. Feutz

(b) Address 4828 natural Bridge Boulevard

19. (a) 9-23-48 (b) Carla J. Shapiro
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4038 Green Lea Place
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 19th
year 1948 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from..... 19.....
DIED WITHOUT MEDICAL ATTENDANCE 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Cause unknown

Due to.....
Good

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....

Underline the cause of 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?..... (Specify type of place)

While at work?..... (Specify type of place)

Carla J. Shapiro (M. D. or other) 10-6-48
Address. COMMISSIONER OF HEALTH Date signed

JAN 22 1949

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 Ralph C. Linders
Licensed Embalmer No. 4275
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 this body is not embalmed, fact should be so stated above.