

FILED FEB 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6781**  
**1413**  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. <b>6781</b> <b>1413</b>	
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, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>30 yrs.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		17 9	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>3329 Illinois</b>				d. STREET ADDRESS (If rural, give location) <b>3329 Illinois</b>			
3. NAME OF DECEASED a. (First) <b>EDWARD</b>			b. (Middle) <b>WACKER</b>			c. (Last) _____	
4. DATE OF DEATH (Month) (Day) (Year) <b>FEB. 13, 1949</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Feb. 3, 1863</b>		9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days		IF UNDER 2 WKS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Waterloo Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Jacob Wacker</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>			14. NAME OF HUSBAND OR WIFE <b>Sophia Wacker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Sophia Wacker</b> ADDRESS <b>3329 Illinois</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause: (a) stating the underlying cause last.  DUE TO (b) <b>920</b>							
DUE TO (c) _____							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Senility</b>							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>2-11</b> , 1949, to <b>2-13</b> , 1949, that I last saw the deceased alive on <b>2-12</b> , 1949, and that death occurred at <b>2:30 A</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Eugene H. Edle M.D.</b>				23b. ADDRESS <b>4971 Chippewa St.</b>		23c. DATE SIGNED <b>2-14-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>3/15/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis MO.</b>	
DATE REC'D BY LOCAL REG. <b>FEB 14 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Foster</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Ziegenhain &amp; Sons</b> ADDRESS <b>7027 Grannis</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.48

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**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.

Signed

*Francis J. Quinn*

Signed.....

Student Embalmer

Licensed Embalmer No. *2245*

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.