

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21956

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

FILED JUL 7 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 1427

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

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS 91</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CLAYTON</u>		c. LENGTH OF STAY (in this place) _____	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS COUNTY HOSPITAL</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>LOUIS</u>		b. (Middle) _____ c. (Last) <u>WAHLBRINK.</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 13 1949</u>			
5. SEX <u>M U</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>FEB. 10, 1869</u>
9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>4</u>	IF UNDER 24 HRS. Hours <u>3</u>	IF UNDER 1 MIN. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>ST CHARLES Co., MO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>HENRY WAHLBRINK</u>		13b. MOTHER'S MAIDEN NAME <u>CATHERINE SCHAMMA</u>	
14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Geo Wahlbrink - St Louis, Mo.</u>		ADDRESS _____	
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) <u>generalized arteriosclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Discontinence</u> <u>Cerevic insufficiency</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 <u>6-13, 1949</u> to <u>6-13, 1949</u> , that I last saw the deceased alive on <u>6-13, 1949</u> , and that death occurred at <u>9:20</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>John Wm. Jones MD</u>		(Degree or title) _____	
23b. ADDRESS <u>601 Greenwood</u>		23c. DATE SIGNED <u>6-14-49</u>	
24a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JUNE 17, 1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ST. CHARLES, MO.</u>	
DATE REC'D BY LOCAL REG. <u>6-17-49</u>		REGISTRAR'S SIGNATURE <u>Thurman Livingston MD</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Hackmann-Cave, Inc</u>		ADDRESS <u>St Charles, Mo</u>	

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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.

Student .....  
Student Embalmer

Signed Frederic W. Bane

Licensed Embalmer No. 4607

P. O. Address St. Charles, 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.