

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **39289**

FILED DEC 14 1950

BIRTH NO. **98187-FA** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3069** Registrar's No. **2916**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, write RURAL and give township) <b>Richmond Heights</b>		c. LENGTH OF STAY (In this place) <b>20</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Overland</b> <b>4201</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Marys Hospital</b>			d. STREET ADDRESS (If rural, give location) <b>9519-Bataan Dr.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Stephen</b> b. (Middle) <b>Marlowe</b> c. (Last) <b>Waggoner</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 2, 1950</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>Nov. 29, 1950</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Days IF UNDER 24 Hrs. Min. <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nil</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>nil</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond Heights</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Winston M. Waggoner</b>		13b. MOTHER'S MAIDEN NAME <b>Patricia Marie Keith</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Winston M. Waggoner 9519-Bataan Overland-21</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBRAL ANOXIA</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>COLLAPSED UMBILICAL CORD BEFORE BIRTH</b> DUE TO (c)   II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>  <b>7610</b>
19a. DATE OF OPERATION <b>-</b>	19b. MAJOR FINDINGS OF OPERATION  <b>63</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>7610</b>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>60</b>	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) <b>-</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>-</b>			
22. I hereby certify that I attended the deceased from <b>Nov. 29, 1950</b> , to <b>DEC. 2, 1950</b> , that I last saw the deceased alive on <b>DEC. 2, 1950</b> , and that death occurred at <b>4:50 a. m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>Robert John Burkhardt, M.D.</b>		23b. ADDRESS <b>St. Marys Group Hospital</b>		23c. DATE SIGNED <b>DEC. 2, 1950</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>12-4-1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Park</b>	24d. LOCATION (City, town, or county) (State) <b>Wellston, Mo.</b>		
DATE REC'D BY LOCAL REG. <b>12/4/50</b>	REGISTRAR'S SIGNATURE <b>Herbert P. Tomko</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Barinann Bros</b>		ADDRESS <b>2504-Woodson Rd. - Overland-14-Mo.</b>	

(Licensed Embalmer's Statement, on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD 0

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed Walter F. Mueller

Licensed Embalmer No. 3039

P. O. Address Overland 14 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.