

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21493

FILED JUN 23 1951

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State File No. _____

Registrar's No. 5364

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 5364	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS,		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS,		2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY HOSPITAL # 1				d. STREET ADDRESS (If rural, give location) 3206 BARRETT ST.			
3. NAME OF DECEASED (Type or Print) a. (First) MARIE		b. (Middle) _____		c. (Last) WAGNER		4. DATE OF DEATH (Month) (Day) (Year) 6/11/51	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 10/17/1917		9. AGE (In years last birthday) 33	If UNDER 1 YEAR Months _____ Days _____	If UNDER 6 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOHN P. CARMODY			13b. MOTHER'S MAIDEN NAME MARY MEEHAN		14. NAME OF HUSBAND OR WIFE JAMES GEORGE WAGNER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. # _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JAMES GEORGE WAGNER 3206 BARRETT ST.			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sodium Fluoride Poisoning self administered in her room the Miami Hotel 809 770 Grand Blvd on June 11th 1951 at about 1:30pm II. OTHER SIGNIFICANT CONDITIONS Suicide while suffering from temporary insanity					INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION Aberration				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) Suicide		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hotel		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo.			
21d. TIME OF INJURY June 11 5:15 p.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 89717			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:05 p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Patrick E. Taylor, Coroner				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 6.12.51	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 6/15/51	24c. NAME OF CEMETERY OR CREMATORY CALVARY		24d. LOCATION (City, town, or county) (State) St. Louis Mo.		
DATE REC'D BY LOCAL JUN 12 1951		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE AVE			

WRITE PLAINLY—USING 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 _____

working under my personal supervision.

Signed.....

Student Embalmer

Signed

Ben Stiffman

Student Embalmer No.....

Licensed Embalmer No. *4366*

P. O. Address *Stow, MA*

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.