

FILED SEP 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28860
7655

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>0</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or town St. Louis, Missouri)		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1</u>				d. STREET ADDRESS (If rural, give location) <u>2205 MENARD 0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>VIRGINIA</u>		b. (Middle) <u>ANN</u>		c. (Last) <u>WILDE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 26 1951</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>DEC. 20 1921</u>	
9. AGE (In years last birthday) <u>29</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 6 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>LOY LANG BOX CO</u>		11. BIRTHPLACE (State or foreign country) <u>ST. LOUIS MO 0</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>CLARENCE ENGLE</u>		13b. MOTHER'S MAIDEN NAME <u>FRIEDA MOLNER</u>		14. NAME OF HUSBAND OR WIFE <u>VERNON WILDE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>VERNON WILDE 2205 MENARD</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>unknown disease of central nervous system</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.				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
19a. DATE OF OPERATION <u>8/25/51</u>		19b. MAJOR FINDINGS OF OPERATION <u>ventriculograms - normal</u>				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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>340.7</u>			
22. I hereby certify that I attended the deceased from <u>8-22-51</u> , 19 <u>51</u> , to <u>8-26-51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>8-26-51</u> , 19 <u>51</u> , and that death occurred at <u>12:30P m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Andrew J. Hahn M.D.</u>		23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED: <u>8-27-51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUG. 29 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>AUG 29 1951</u>		REGISTRAR'S SIGNATURE <u>Earl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutis 2906 Gravois</u>			

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

Student Embalmer No. _____

Signed *James C. Wiley*

Licensed Embalmer No. *4347*

P. O. Address *2906 Travis*

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.