

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12465

State File No.

FILED MAR 31 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **2662**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Clayton	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) # 3 Hillvale Drive	

3. NAME OF DECEASED (Type or Print) Corinne		4. DATE OF DEATH (Month) (Day) (Year) March 9, 1953	
5. SEX F.		6. COLOR OR RACE W.	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.		8. DATE OF BIRTH Sept. 19, 1901	
9. AGE (In years last birthday) 51		10. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Edwin H. Wagner Sr.	13b. MOTHER'S MAIDEN NAME Cora Shevvin	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. not known	17. INFORMANT'S SIGNATURE OR NAME Mr. Edwin H. Wagner Sr.	ADDRESS # 3 Hillvale Drive
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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		19. INTERVAL BETWEEN ONSET AND DEATH 20 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension, Val. disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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 H43X
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22. I hereby certify that I attended the deceased from **Dec 1941, 19**, to **3/9/53, 19**, that I last saw the deceased alive on **3/1/53, 19**, and that death occurred at **3 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE W. H. Walsh	(Degree or title)	23b. ADDRESS 10 S. Kingshighway	23c. DATE SIGNED 3/9/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 12, 1953	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 10 1953	REGISTRAR'S SIGNATURE J. E. Smith	25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Connelly	ADDRESS 3840 Lindell Blvd.
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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 me

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed [Signature]
.....

Licensed Embalmer No. 4699

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.