

XC 2 233 341
SL 3770

FILED APR 12 1957

STANDARD CERTIFICATE OF DEATH

318

Primary Registration District No. 1003

11289
STATE FILE NUMBER

2521
Registrar's No.

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN 915 N. Grand St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V. A. HOSPITAL		Length of stay in lb 32 Days	d. STREET ADDRESS (If outside, give location) 112 N. 8TH ST. Apt 304		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle J Last WILFORT			4. DATE OF DEATH Month 3 Day 12 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/87	9. AGE (In years last birthday) 69 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (City and state or country) Leon, France		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Nick Wilfort.			14. MOTHER'S MAIDEN NAME Angeline (Maiden name unknown)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) Yes WW-1		16. SOCIAL SECURITY NO. 498 09 0078	17. INFORMANT Address V. A. HOSPITAL RECORDS ST. LOUIS, MO.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO CORONARY ARTERIOSCLEROSIS					INTERVAL BETWEEN ONSET AND DEATH UNK
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NONE			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 2/8/57 to 3/12/57 and last saw her him alive on 3/12/57 Death occurred at 9:40 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Type or print) M. D.			22b. ADDRESS VAHOSPITAL ST. LOUIS 6 MO.		22c. DATE SIGNED 3/12/57
23a. BURIAL OR CREMATION (Type or print) Removal 3/15/57		23b. NAME OF CEMETERY OR CREMATORY National Cem.		23d. LOCATION (City, town, or county) (State) Jefferson Bks. Mo	
24. FUNERAL DIRECTOR ADDRESS Edward Fendler 5611 South Grand Blvd.			25. DATE RECD. BY LOCAL REG. MAR 13 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith Mo MBB

1000

STATE OF ILLINOIS

DEPARTMENT OF HEALTH

EMBALMER

CERTIFICATE

NO.

20

1911

FILE

1911

100

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

(In compliance with Act of 1911)

DEPARTMENT OF HEALTH

STATE OF ILLINOIS

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

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
Signature of Student Embalmer

Signed *Harry J. Schumacher*
Licensed Embalmer No. *267*

P. O. Address *6611 S. Swan*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.