

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26939
STATE FILE NUMBER

FILED AUG 5 1957

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1831

Health, Welfare, Public Service
 300 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
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1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u>		a. STATE <u>Missouri.</u>		b. COUNTY <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>524 Greeley Ave.</u>		Length of stay in lb <u>9 Yrs.</u>		c. CITY OR TOWN <u>Webster Groves</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
				d. STREET ADDRESS <u>524 Greeley Ave</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Dorothyann</u> Middle <u>Wagner.</u> Last <u>Wagner.</u>				Month <u>July</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1905</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home.</u>		11. BIRTHPLACE (City and state or country) <u>Chicago Illinois.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Hallinger</u>				14. MOTHER'S MAIDEN NAME <u>Stella Asp.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None.</u>		17. INFORMANT Address <u>Dr. O. Walter Wagner 524 Greeley Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple sclerosis</u>						<u>15 yrs.</u>	
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) <u>Pyelonephritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>345x</u>					
20c. TIME OF INJURY Hour _____ 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		20g. COUNTY STATE	
21. I attended the deceased from <u>5/2/52</u> to <u>7/20/57</u> and last saw her alive on <u>7/19/57</u> Death occurred at <u>5 P. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>W. F. Melick MD</u> (Office or title)				22b. ADDRESS <u>3720 Washington</u>		22c. DATE SIGNED <u>7-22-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation.</u>		23b. DATE <u>7/22/1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Chapel of Memories</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Calvin F. Feutz Funeral Home.</u> <u>4828 Natural Bridge Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>7/23/57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Dombek MD</u>	

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... *Ralph C. Zindler*

Licensed Embalmer No... 42

P. O. Address... *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.