

Health,
& Welfare
Public
Service

FILED NOV 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39857
STATE FILE NUMBER

Registration District No. 118 Primary Registration District No. 3020 Registrar's No. 241

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Washington</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>		Length of stay in 1b <u>50 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>P.R.2, Box 349</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>M.</u> Last <u>Wunderlich</u>			4. DATE OF DEATH Month - Day Year <u>Nov. 11, 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>Sept. 11, 1907</u>		9. AGE (In years last birthday) <u>50</u> Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Washington, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William A. Straatmann</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Narup</u>		14. NAME OF HUSBAND OR WIFE <u>Adolph Wunderlich</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>Adolph Wunderlich, Washington, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia and Parasitosis</u>			INTERNAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
Conditions, if any, which gave rise to above cause (a), starting 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>Rheumatoid Arthritis for 25 years</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.)		
20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m.			20d. INJURY OCCURRED WHILE AT <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 <u>Washington, Mo.</u>		COUNTY	STATE
21. I attended the deceased from <u>Nov. 10, '57</u> to <u>Nov. 11, '57</u> and last saw her alive on <u>Nov. 11, 1957</u> Death occurred at <u>6:45 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) <u>John B. Ryan, M.D.</u>		22b. ADDRESS <u>Washington, Mo.</u>		22c. DATE SIGNED <u>11-12-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 14, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, Missouri</u>	
24. FUNERAL DIRECTOR <u>Waburg & Witt, Inc.</u>		ADDRESS <u>Washington, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11/14/57</u>	26. REGISTRAR'S SIGNATURE <u>J.P. Widmann & J.P. Widmann</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

NOV 25 1957

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 *Lester A. Witt*

Licensed Embalmer No. *3254*
P. O. Address *Washington*

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.