

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46426

STATE FILE NUMBER

FILED DEC 30 1957

318

1003

12267

Registration District No.

Primary Registration District No.

Registrar's No.

S. 300
v. 1-57

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 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 25 ST. LOUIS CITY HOSP. #1.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 217 1/2 3152a Park Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES WAGSTAFF			4. DATE OF DEATH DEC. 20, 1957 Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/74		9. AGE (In years last birthday) 83 F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE None		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. None	
17. INFORMANT Mary Smith 3152a Park Ave. St. Louis		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCT. OF RIGHT OCCIPITAL CORTEX, RECENT. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) 332x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) BRONCHOPNEUMONIA OF LEFT LUNG BASE		INTERVAL BETWEEN ONSET AND DEATH ?	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
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 11/21/57 to 12/20/57 and last saw her alive on 12/20/57 Death occurred at 3:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert F. Owen, M.D.		22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 12/20/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/21/57		23c. NAME OF CEMETERY OR CREMATORY St. Marcus Cemetery	
23d. LOCATION (City, town, or county) St. Louis, Missouri		23e. STATE (State)			
24. FUNERAL DIRECTOR Chulick Und. Co. 1722 So. Jeff.		25. DATE RECD. BY LOCAL REG. DEC 21 57		26. REGISTRAR'S SIGNATURE Carl Smith MD mjs	

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.

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 *Flourance M. Bills*
Licensed Embalmer No. *4375*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.