

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023854

STATE FILE NUMBER

1003

Registrar's No. 5494

FILED JUN 16 1958

Registration District No.

318

Primary Registration District No.

S. 300
1-57
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mo.		b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Webster Groves	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp.		Length of stay in lb 6 wks.		d. STREET ADDRESS (If outside, give location) 27 1416 Gardenia	
3. NAME OF DECEASED (Type or print) First HAZEL Middle P. Last WANDER			4. DATE OF DEATH Month Day Year May 25, 1958		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 23, 1906	9. AGE (in years last birthday) 52	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Lafayette E. Pickett		13b. MOTHER'S MAIDEN NAME Buford Sallee	
14. NAME OF HUSBAND OR WIFE Elmer F. Wandler		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. 495-40-1035	
17. INFORMANT E. F. Wandler		Address 1416 Gardenia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cyst Adenocarcinoma Rt. Ovary</i>					INTERVAL BETWEEN ONSET AND DEATH 1 3 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Carcinomatosis, abdomen & lung</i>					2 mos.
DUE TO (c) <i>Severe Bone marrow depression. Blood cell stained both lung cavities.</i>					a few days.
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 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.) 175.0		
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		COUNTY	STATE
21. I attended the deceased from Feb 1957 to May 24 1958 and last saw her alive on May 25 1958 Death occurred at 1:05 pm May 25 1958 m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE A. Victor Reese (Degree or title) M.D.			22b. ADDRESS 120 East Lockwood Webster Groves Mo		22c. DATE SIGNED 5/26/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-27-58	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or country) Kinkwood, Mo. (State)
24. FUNERAL DIRECTOR Parker-Aldrich Webster Groves			25. DATE RECD. BY LOCAL REG. MAY 26 58		26. REGISTRAR'S SIGNATURE J. Carl Smith Mo. M.D.

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 *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Walter Grove*

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.