

FILED SEP 29 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034795  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8806

300

1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Affton	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS 7949 S Rock Hill Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last WARD E. WAMPLER		4. DATE OF DEATH Month Day Year SEPTEMBER 10, 1958	
5. SEX M	6. COLOR OR RACE O W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ins. Manager		10b. KIND OF BUSINESS OR INDUSTRY Am. Lead & Zinc	11. BIRTHPLACE (City and state or country) Shell City Mo. 0
13a. FATHER'S NAME Philip Wampler		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Eleanor Wampler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 490-03-6795	17. INFORMANT Mrs. W.E. Wampler 7949 S R. Hill Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL HEMORRHAGE, CAUSE UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH 12 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (as related to the terminal disease conditions shown in PART I (c)) CONGESTIVE HEART FAILURE, MILD. ARTERIOSCLEROTIC HEART DISEASE. PULMONARY EMPHYSEMA			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
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.)	
21. I attended the deceased from AUG. 29, 1958 to SEPT. 10, 1958 and last saw her alive on SEPT. 10, 1958 Death occurred at 10:45 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) M. D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 9/11/58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or country) (State)
Removal	9-12-1958	Ozark Memorial Cem.	Joplin Mo.
24. FUNERAL DIRECTOR Parker-Aldrich Webster Groves		25. DATE RECD. BY LOCAL REG. SEP 1 2'58	26. REGISTRAR'S SIGNATURE J. Smith MO m & B.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symbols will be marked. 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 Helch* .....

Licensed Embalmer No. *4395* .....  
P. O. Address *Wester Grand* .....

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.