Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003597
STATE FILE NUMBER

FILED FEB 16 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 784

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. John's Hosp. — Length of stay in Ib
d. STREET ADDRESS (If outside, give location): 7511 Suffolk Ave. — Reside on Farm: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN: Shrewsbury 4561 — Inside Limits: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: JOHN — Middle: — Last: WAGNER

4. DATE OF DEATH: Month: Jan. — Day: 22 — Year: 1959

5. SEX: Male 0

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Jan. 16, 1903

9. AGE (In years last birthday): 56 — IF 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): Upholsterer-Appel

10b. KIND OF BUSINESS OR INDUSTRY: Upholstering Co.

11. BIRTHPLACE (City and state or country): Austria-Hungary 4

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Michael Wagner

13b. MOTHER'S MAIDEN NAME: Marion Degel

14. NAME OF HUSBAND OR WIFE: Theresa Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 492-03-9152

17. INFORMANT: Theresa Wagner — Address: 7511 Suffolk Ave.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gangrene of stomach with — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): generalized metastasis

DUE TO (c): 151X

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 ☐ NO ☒ 2

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 7-28-58 to 1-22-59 and last saw him alive on 1-21-59
Death occurred at 2:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] — (Degree or title): MD 0

22b. ADDRESS: 832 N Broadway

22c. DATE SIGNED: 1-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: Jan. 24, 1959

23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Kriegshauser — ADDRESS: 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG.: JAN 23 '59

26. REGISTRAR'S SIGNATURE: Karl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.