

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007748

STATE FILE NUMBER

2-1312

FILED FEB 24 1959

Registration District No. _____ Primary Registration District No. _____

Registration No. _____

300
-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Jennings</u> <u>4138</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DePaul Hosp</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>8928 Mayfield Ct</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>SUSIE</u> Middle _____ Last <u>Wagner</u>			4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>59</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>5-18-1886</u>		9. AGE (In years last birthday) <u>72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Montgomery City Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Chas Sours</u>		13b. MOTHER'S MAIDEN NAME <u>Chapman</u>	
14. NAME OF HUSBAND OR WIFE <u>EDDIE</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 <u>Eddie Wagner</u>		Address <u>8928 Mayfield Ct</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>Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) <u>A.S.H.D. 420.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute Cholecystitis (post operative)</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>?</u>		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 <u>Feb 1957</u> to <u>Feb 1959</u> and last saw her/him alive on <u>Feb 5, 1959</u> Death occurred at <u>7:30 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>M. Cecelia Riechert M.D.</u>		22b. ADDRESS <u>539 N. Grand Blvd</u>		22c. DATE SIGNED <u>2/6/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>2-9-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	
23d. LOCATION (City, town, or county) <u>St Louis Co</u>		(State) <u>MO</u>		24. FUNERAL DIRECTOR <u>A. Kross</u>	
ADDRESS <u>2707 N. Grand</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 6 '59</u>		26. REGISTRAR'S SIGNATURE <u>Walter Smith. M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

7112

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 *Howey - Kahl*

Licensed Embalmer No. *4596*
P. O. Address *Flouissant, 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.