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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011546

STATE FILE NUMBER

FILED MAR 25 1959

Registration District No.

Primary Registration District No.

Registrar's **2 2454**

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
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 St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4501 Gravois		Length of stay in 1b	d. STREET ADDRESS 4501 a Gravois
3. NAME OF DECEASED (Type or print) First William Middle A. Last Wunderlich			4. DATE OF DEATH Month Mar. Day 8, Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. 71 Months 7 Days 7 Hours 7 Min.
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Henry Wunderlich		13b. MOTHER'S MAIDEN NAME unk.	14. NAME OF HUSBAND OR WIFE Vera Wunderlich
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. 486-38-7973	17. INFORMANT Address Vera Wunderlich 4501 Gravois
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 3 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) 420.1			
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 checked="" 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 _____ 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 9/8/57 to 3/3/59 and last saw him alive on 3/8/59 Death occurred at 11:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE B. J. Mc Ginnis M.D.		22b. ADDRESS 16 Hampton Village	22c. DATE SIGNED 3/9-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 11, 1959	23c. NAME OF CEMETERY OR CREMATORY S.S. Peters & Paul	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Schumacher's 3013 Meramec St.		25. DATE RECD. BY LOCAL REG. MAR 10 '59	26. REGISTRAR'S SIGNATURE Roal Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

12-3-59

Mr. J. Mc Ginnis
FL 1-3061
16 Thompson Village

2100 P.M.

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 *Jack Haupt*

Licensed Embalmer No. *4746*

P. O. Address *St. Louis*

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.