

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027317

FILED VS AUG 17 1959

2 2003

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | |
|--|--|---|---|
| 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 Saint Louis | | Length of stay in 1b | c. CITY OR TOWN Florissant, |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1595 Gallop Lane, |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | | | |
|-------------------------------------|---------------|----------------|---------------------|----------------------|-------|-----|------|
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| | GEORGE | JOHNSON | WALDRAM, JR. | July 27, 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 9-24-19 | 9. AGE (last birthday) 39 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|

| | | | |
|--|---|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | 10b. KIND OF BUSINESS OR INDUSTRY Mc Donnell Aircraft | 11. BIRTHPLACE (City and state or country) Pacific, Missouri | 12. CITIZEN OF WHAT COUNTRY USA |
|--|---|--|---|

| | | |
|---|--|---|
| 13a. FATHER'S NAME George J. Waldram, Sr. | 13b. MOTHER'S MAIDEN NAME Virginia Mauzy | 14. NAME OF HUSBAND OR WIFE Shirley Waldram |
|---|--|---|

| | | | |
|---|---|---|-----------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War #2 | 16. SOCIAL SECURITY NO. 488-20-6143 | 17. INFORMANT Shirley Waldram, 1595 Gallop Lane, Flori- | Address ssant, Mo |
|---|---|---|-----------------------------|

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH 4 days |
| IMMEDIATE CAUSE (a) | Encephalomalacia, left hemisphere | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | 332x |

| | |
|---|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|---|--|

| | | |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.) |
|---|---|--|

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

| | | | | |
|--|--|------------------------------|--------|-------|
| 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 July 24, 1959 to July 27, 1959 and last saw ^{her} him alive on July 26, 1959 |
| Death occurred at 1:45 A m on the date stated above, and to the best of my knowledge, from the causes stated. |

| | | |
|--|---|------------------------------------|
| 22a. SIGNATURE (Degree or title) Robert C. Kugzland MD | 22b. ADDRESS 14 FORSYTH WALK CLAYTON 5, MO. | 22c. DATE SIGNED 7-28-59 |
|--|---|------------------------------------|

| | | | |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 7-30-59 | 23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri |
|---|-----------------------------|---|--|

| | | |
|--|--|--|
| 24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, Saint Louis, 15, Missouri | 25. DATE RECD. BY LOCAL REG. JUL 28 59 | 26. REGISTRAR'S SIGNATURE Harold Smith, M.D. |
|--|--|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 John A. Mlusa
Licensed Embalmer No. 4186

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.