

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030899

FILED VS SEP 8 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7684**

| | | | | | | | |
|---|---|---|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | | Length of stay in 1b 3 days | | c. CITY OR TOWN Jennings | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 7206 Harney | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Florence Middle I. Last Wilhelm | | | | 4. DATE OF DEATH Month Aug. Day 17 Year 1959 | | | |
| 5. SEX female | 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 10/4/1910 | 9. AGE (last birthday) 48 yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (City and state or country) St. Louis Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME William Lafsu | | | 13b. MOTHER'S MAIDEN NAME Cora Dang | | 14. NAME OF HUSBAND OR WIFE Walter Wilhelm | | |
| 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. 494-03-3363 | | 17. INFORMANT Walter Wilhelm Address 7206 Harney | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Cirrhosis with Ascites Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 581.0 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 mos. |
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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. | 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 8/13/59 to 8/17/59 and last saw her alive on 8/17/59 Death occurred at 12:05 AM on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> (Degree or title) _____ | | | | 22b. ADDRESS 6917 W Florissant Ave | | 22c. DATE SIGNED 8/18/59 (State) _____ | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 8/19/59 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) St. Louis | | Mo. | |
| 24. FUNERAL DIRECTOR Buchholz Mort. 5967 W. Florissant Av. ADDRESS _____ | | | 25. DATE RECD. BY LOCAL REG. AUG 18 '59 | | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

LP

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Richard A. Buckner*

Licensed Embalmer No. 4551

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.