

**FEDERAL BUREAU OF INVESTIGATION  
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038192**

**FILED VS NOV 12 1959**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **210020**

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ALEXIAN BROS. Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>4466 S. 39th</b>	

<b>3. NAME OF DECEASED</b> First Middle Last <b>JOHN E. WAPPLER</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>OCT. 30 1959</b>		
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>AUG. 27 1909</b>	<b>9. AGE</b> (last birthday) <b>50</b>	<b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>WAREHOUSEMEN</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>MONSANTO CO</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>MO</b>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>					

<b>13a. FATHER'S NAME</b> <b>FRED WAPPLER</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>AMELIA OSTERTAG</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>HARRIET WAPPLER</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>492-05-7179</b>		<b>17. INFORMANT</b> Address <b>HARRIET WAPPLER, 4466 S. 39th</b>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>min.</b>
<b>IMMEDIATE CAUSE (a)</b> <b>Cardiac arrest</b>			
<b>CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b>			
<b>DUE TO (b)</b> <b>Coronary sclerosis</b>			<b>?</b>
<b>DUE TO (c)</b> <b>febrile arterio sclerosis 420.1</b>			<b>?</b>

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a) <b>Post op (Aug 10-27-59) cholecystectomy</b>		<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year a.m. p.m.			

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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**21. I attended the deceased from** **10-20-59** to **10-30-59** and last saw <sup>her</sup>him alive on **10-29-59**  
Death occurred at **12:45** **A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <b>R. Neckmeyer M.D.</b>	<b>22b. ADDRESS</b> <b>4065 S. Grand</b>	<b>22c. DATE SIGNED</b> <b>10/31/59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>REMOVAL</b>	<b>23b. DATE</b> <b>NOV 6 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>310N CEMETERY</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>ST LOUIS MO</b>
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<b>24. GENERAL DIRECTOR</b> ADDRESS <b>Thomas Kates 2906 Beavie</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>NOV 2 1959</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Loal Smith, M.D.</b>
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*m & d.*

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ENDED

**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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 So

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.