

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042672

FILED VS NOV 3 0 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210678**

1. PLACE OF DEATH a. COUNTY <u>CITY</u>		2. USUAL RESIDENCE (Where deceased lived.) If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>JEFFERSON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Length of stay in 1b <u>2 days</u>	c. CITY OR TOWN <u>HIGH RIDGE MO</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DEARONESS HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Hwy 30</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>WALLACH</u> Last _____			4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/2/27</u>	9. AGE (last birthday) <u>80</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 <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>GERMANY</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>AUGUST SCHEEL</u>		13b. MOTHER'S MAIDEN NAME <u>MATHILDA LESNICK</u>		14. NAME OF HUSBAND OR WIFE <u>FRANK J. WALLACH</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>RALPH WALLACH HIGH RIDGE MO</u> Address _____	

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 <u>2 weeks</u>
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>		
DUE TO (c) <u>450.0</u>			

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	
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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 NOV. 2, 1959 to NOV. 18, 1959 and last saw her him alive on NOV. 18, 1959
Death occurred at 12:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul Rosenberg D.O.</u>		22b. ADDRESS <u>9302 Gravois</u>		22c. DATE SIGNED <u>11-19-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11/21/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST MARTIN'S Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>High Ridge Mo</u>	
24. FUNERAL DIRECTOR <u>Brimm & Funeral Home House Springs Mo</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 19 1959</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u> S.P.	

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 Clarence M. Bills

Licensed Embalmer No. 4375

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.