

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021764

FILED VS MAY 31 1960

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1505 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St Louis</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>MIRKWOOD Mo</u>		Length of stay in 1b <u>1 da.</u>	c. CITY OR TOWN <u>FENTON 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>ST JOSEPH HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RR #1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>AUGUST</u> Middle <u>D.</u> Last <u>WALLACH</u>			4. DATE OF DEATH Month <u>5</u> - Day <u>8</u> - Year <u>60</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3-1904</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hwy Dept.</u>		11. BIRTHPLACE (City and state or country) <u>House Springs Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>FRANK WALLACH</u>		13b. MOTHER'S MAIDEN NAME <u>BARBARA KULAK</u>		14. NAME OF HUSBAND OR WIFE <u>FREDERICKA 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>495-34-2017</u>		17. INFORMANT <u>FREDERICKA WALLACH FENTON Mo RA</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
IMMEDIATE CAUSE (a) <u>Encephalitis</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> Natural causes <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Natural disease process</u>
20c. TIME OF INJURY Hour <u>8:30</u> Minute <u>00</u> Month, Day, Year <u>5/7/60</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>exterior of home premises</u>	20f. CITY, TOWN, OR LOCATION <u>Fenton</u>	COUNTY <u>Jefferson</u>	STATE <u>Missouri</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Raymond M. Harsh</u> (Degree or title) <u>Coroner</u>	22b. ADDRESS <u>Clayton, Mo.</u>	22c. DATE SIGNED <u>5/17/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5/11/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST PHILOMENAS Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>HOUSE SPRINGS Mo</u>
24. FUNERAL DIRECTOR <u>BRIMMER FUNERAL HOME</u>	ADDRESS <u>House Springs Mo</u>	25. DATE RECD. BY LOCAL REG. <u>5-9-60</u>	26. REGISTRAR'S SIGNATURE <u>J. B. Mumfley M.D.</u>

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

JUL 22 1960

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 Herbert J. Law Jr.

Licensed Embalmer No. 4800

P. O. Address Thibodaux

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.