

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025297

FILED VS JUN 20 1960

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1692 STATE FILE NUMBER

ENDED

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| 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>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Hts.</u> | | Length of stay in 1b <u>HRS.</u> | c. CITY OR TOWN <u>Clayton</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>7553 York Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>G.</u> Last <u>WADDELL</u> | | | 4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</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>1-14-1901</u> | 9. AGE (last birthday) <u>59</u> | IF UNDER 1 YEAR Months Days Hours | IF UNDER 24 HR Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Inspector-Missouri Inspection Bureau</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Lexington, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>William B. Waddell</u> | | 13b. MOTHER'S MAIDEN NAME <u>Katie Graendorf</u> | | 14. NAME OF HUSBAND OR WIFE <u>Marguerite R. Waddell</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>490-01-7952</u> | | 17. INFORMANT Address <u>Marguerite R. Waddell 7553 York Dr.</u> | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>8 Hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>✓</u> | | 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 type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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. <u>✓</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.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
| 21. I attended the deceased from <u>1950</u> to <u>5/29/60</u> and last saw him alive on <u>5/29/60</u> Death occurred at <u>10:00 A.</u> on the date stated above, and to the best of my knowledge from the causes stated. | | | |

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| 22a. SIGNATURE (Degree or title) <u>James J. Pugh M.D.</u> | | 22b. ADDRESS <u>730 Hodson Ave.</u> | | 22c. DATE SIGNED <u>5/30/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (Rail)</u> | | 23b. DATE <u>May 31, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u> | 23d. LOCATION (City, town, or county) (State) <u>Lexington, Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 9450 Olive St. Road</u> | | 25. DATE RECD. BY LOCAL REG. <u>5-30-60</u> | 26. REGISTRAR'S SIGNATURE <u>John B. Manly M.D.</u> | |

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed P.W. Storrland

Licensed Embalmer No. 4007

P. O. Address _____

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.