

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 10 1960

-60-028899

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7018

UNRECORDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS MO</u>		Length of stay in 1b <u>3 DAYS</u>	c. CITY OR TOWN <u>WEBSTER GROVES</u>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>COMMUNITY HOSPITAL</u>		Inside Limits No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>628 CORNEL</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>DEWEY</u> Middle <u>G</u> Last <u>WAGNER</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>10</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</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>Oct 22 1898</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min.

10. USUAL OCCUPATION (Give kind of work done during last 12 months, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
<u>LABORER</u>		<u>STEEL</u>	<u>GLENCOE MO</u>	<u>U.S.A.</u>
13a. FATHER'S NAME <u>SAMUEL WAGNER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY HAWKINS</u>		14. NAME OF HUSBAND OR WIFE <u>DIMPLE WAGNER</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give branch or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>48676-0430</u>	17. INFORMANT <u>Marie Wagner 626 Elm Ave</u>
---	--	--

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>Carcinoma of the larynx - metastatic</u>		
DUE TO (b) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (c) <u>163+</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 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.		

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 Sept 14 59 to July 16 1960 and last saw ^{him} him alive on July 10, 1960
Death occurred at 6:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J.W. Howard</u>	(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>5593 Crown Rd</u>	22c. DATE SIGNED <u>7-12-60</u>
--------------------------------------	----------------------------------	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>July 13, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pathe Decker</u>	23d. LOCATION (City, town, or county) <u>Crestwood Mo</u>
--	-----------------------------------	---	--

24. FUNERAL DIRECTOR <u>J.J. Gaudin & Sons 1716 Yellow</u>	25. DATE RECD. BY LOCAL REG. <u>JUL 13 1960</u>	26. REGISTRAR'S SIGNATURE <u>Howard Smith, 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edward J. Ford

Licensed Embalmer No. 4211

P. O. Address 3561 S. Webster St.

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.