

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 4 1960

60-028912

7203

STATE FILE NUMBER

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

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO | | Length of stay in 1b 3 Days | c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 7309 S. BROADWAY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First ALBERT Middle WASCHOW Last | | | 4. DATE OF DEATH Month JULY Day 17, Year 1960 | |
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| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8/25/1875 | 9. AGE (last birthday) 84 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CITY EMPLOYEE (RETIRED) | 10b. KIND OF BUSINESS OR INDUSTRY ST. LOUIS, MO. | 11. BIRTHPLACE (City and state or country) ST. LOUIS CO. MO. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME HENRY WASCHOW | 13b. MOTHER'S MAIDEN NAME MINNIE HARTMANN | 14. NAME OF HUSBAND OR WIFE MINNIE |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO | 16. SOCIAL SECURITY NO. 487 36 5594 | 17. INFORMANT Address IDA E. BREAZEALE RT. 1, CHESTERFIELD, MO. |
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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: | | INTERVAL BETWEEN ONSET AND DEATH 1 day 4 yrs. |
| IMMEDIATE CAUSE (a) Myocardial infarct | DUE TO (b) Coronary arteriosclerosis | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (c) 4201 | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Myocardial insufficiency | 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 checked="" type="checkbox"/> NO <input 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.) |
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| 20c. TIME OF INJURY Hour Month, Day, Year s.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 7/14/60 to 7/17/60 and last saw him alive on 7/19/60 |
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| 21. I attended the deceased from 1:10p on 7/14/60 to 7/17/60 and last saw him alive on 7/19/60 Death occurred at _____ m 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) W. Yates Trotter, Jr. M.D. | 22b. ADDRESS 1515 LAFAYETTE AVE | 22c. DATE SIGNED 7/20/60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE JULY 20, 1960 | 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE CEMETERY | 23d. LOCATION (City, town, or county) (State) LEMAY, MISSOURI |
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| 24. FUNERAL DIRECTOR ADDRESS C. HOFFMEISTER MORTUARIES 7814 SO. BROADWAY ST. LOUIS, MO. | 25. DATE RECD. BY LOCAL REG. JUL 19 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

500

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 Lenius E. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 78148

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.