

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036800

FILED VS. SEP 19 1960

317

Primary Registration District No. 548

Registrar's No. 2732

STATE FILE NUMBER

| | | | | | | | | |
|---|---|---|--|---|---|---|----------------|-------|
| 1. PLACE OF DEATH a. COUNTY ST LOUIS | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY ST LOUIS | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP) OR TOWN WEBSTER GROVES | | Length of stay in 1b 16 mo | | c. CITY OR TOWN WEBSTER GROVES | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 586 RIDGE AVE | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 586 RIDGE AVE | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last LAURA ELISHA MANGOLD | | | | 4. DATE OF DEATH Month Day Year 9 - 14 - 1960 | | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 2-10-'85 | 9. AGE (last birthday) 75 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR | | 10b. KIND OF BUSINESS OR INDUSTRY WHIRLPOOL CORP. | | 11. BIRTHPLACE (City and state or country) EVANSVILLE INDIANA | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | |
| 13a. FATHER'S NAME JOHN W SCHWALM | | | 13b. MOTHER'S MAIDEN NAME MINNIE TIEMAN | | 14. NAME OF HUSBAND OR WIFE JOHN S MANGOLD, Dec'd | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 308-18-0982 | 17. INFORMANT Address Lloyd S. McCutcheon 586 Ridge Ave | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 min | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic C. V S disease | | | | | | 4 yrs | | |
| 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 checked="" 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. 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 June 8 / 1960 to Sept 14 / 60 and last saw her alive on 8/30 / 60 Death occurred at 4 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Carl D. Brund MD | | | | 22b. ADDRESS Webster Groves Mo | | 22c. DATE SIGNED 9/15/60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE 9-15-60 | 23c. NAME OF CEMETERY OR CREMATORY PARK LOWN CEMETERY | | 23d. LOCATION (City, town, or county) EVANSVILLE INDIANA | | | | |
| 24. FUNERAL DIRECTOR ADDRESS MITTELBERG Webster Groves Mo | | | 25. DATE RECD. BY LOCAL REG. 9-15-60 | | 26. REGISTRAR'S SIGNATURE John C. Muffley M.D. | | | |

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

Student _____
Signature of Student Embalmer

Signed Elmer R. Jaden

Licensed Embalmer No. 407

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.