

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5538 Beacon Ave.
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First IDA Middle MARIE Last WANGLER			4. DATE OF DEATH Month Dec. Day 3 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/2/1893	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (City and state or country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME Joseph Sommerfeld	13b. MOTHER'S MAIDEN NAME Mary Spechoultz	14. NAME OF HUSBAND OR WIFE Joseph Wangler
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) *****	16. SOCIAL SECURITY NO. None	17. INFORMANT Joseph Wangler 5538 Beacon Ave.
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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) Complete Heart Block arteriosclerotic cardiovascular disease DUE TO (b) 4330 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs years
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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)		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 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 12/4/54 12/3/60	COUNTY	STATE
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21. I attended the deceased from 12/4/54 to 12/3/60 and last saw her/him alive on 12/3/60 Death occurred at 9:30 P 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) Robert A Bauer M.D.	22b. ADDRESS 3731 Goodfellow	22c. DATE SIGNED 12/5/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/7/1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
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24. FUNERAL DIRECTOR JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.	25. DATE RECD. BY LOCAL REG. DEC 6 1960	26. REGISTRAR'S SIGNATURE Loan Smith. M.D.
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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 *JMB Rustin*

Licensed Embalmer No. 3980

P. O. Address St. Louis

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