

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048303

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3683 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. John</u>		c. CITY OR TOWN <u>St. John</u>	
Length of stay in 1b <u>30 Years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3727 Eminence Ave.</u>		d. STREET ADDRESS (If outside, give location) <u>3727 Eminence Ave.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <u>John</u>	Middle <u>Maurice</u>	Last <u>Wagner</u>	4. DATE OF DEATH	Month <u>Dec.</u>	Day <u>19</u>	Year <u>1960</u>
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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>10-2-82</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book keeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Combustion Eng.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>John Wagner</u>	13b. MOTHER'S MAIDEN NAME <u>Nellie Walsh</u>	14. NAME OF HUSBAND OR WIFE <u>Clara M. Wagner</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>492-07-4872</u>	17. INFORMANT Address <u>Clara M. Wagner 3727 Eminence Ave.</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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		<u>48 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic arterial sclerosis H&A</u>	<u>2</u>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Broncho pneumonia</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 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
	e.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
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21. I attended the deceased from Feb 18, 1953 to Dec 19, 1960 and last saw her live on 12/17/60
Death occurred at 7:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Walter Chazy MD</u>	22b. ADDRESS <u>9711 St Charles Road St Louis, Mo</u>	22c. DATE SIGNED <u>12/21/60</u>
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23a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION <u>CREMATION</u>	23b. DATE <u>12-23-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Baumann Bros-Inc. 2504 Woodson Rd-Overland, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-21-60</u>	26. REGISTRAR'S SIGNATURE <u>John M. Murphy M.D.</u>
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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

David C. Wilson

Licensed Embalmer No. 3454

P. O. Address Carleton

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.