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3513

-61-015721

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED APR 24 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				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. LOUIS, MISSOURI</u>			Length of stay in 1b	c. CITY OR TOWN <u>HEFTON</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>11012 MUELLER RL</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>W.</u> Last <u>WAGNER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1961</u>			
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>JAN 21-1898</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>21</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HIWAY MAINTANCE</u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOSEPH WAGNER</u>		13b. MOTHER'S MAIDEN NAME <u>DOROTHIA SASSE</u>		14. NAME OF HUSBAND OR WIFE <u>WILHELMINA WAGNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>				17. INFORMANT Address <u>WILHELMINA WAGNER 11012 MUELLER RD ST LOUIS MO</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>UREMIA</u>							<u>2 WEEKS</u>
DUE TO (b) <u>ACUTE RENAL FAILURE</u> <u>590X</u>							<u>3 WEEKS</u>
DUE TO (c) <u>ACUTE TUBULAR NECROSIS, ETIOLOGY UNDETERMINED</u>							<u>3 WEEKS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CEREBRAL ARTERIOSCLEROSIS</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown	
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.)					
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>							
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 <u>JANUARY 12, 1956</u> to <u>APRIL 11, 1961</u> and last saw her/him alive on <u>APRIL 11, 1961</u> Death occurred at <u>12:35 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E. Vermillion, M.D.</u> (Degree or title)				22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>4/11/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>APR-14-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT Hope Cem.</u>		23d. LOCATION (City, town, or county) <u>Lemay, Mo.</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>FEY FUNERAL HOME MEHLVILLE MO</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>APR 12 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u>		

INTERNATIONAL

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 *Guillermo M. S. S. S.*

Licensed Embalmer No. 4329

P. O. Address *St. Louis, Mo.*

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.