MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-027493

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6995

FILED AUG 8 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 20 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Lutheran Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Country Club Hills
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 7414 Pleaseway Dr.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle G Last WILKE
4. DATE OF DEATH: Month July Day 26 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 9/25/1887
9. AGE (last birthday): 73
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Dry-Goods
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: William Wilke
13b. MOTHER'S MAIDEN NAME: Augusta Poertner
14. NAME OF HUSBAND OR WIFE: Lillie Wilke (nee Mueller)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Ruth Schollmeier Address: Roodhouse, Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immed.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): Arteriosclerotic heart disease — 2 years
DUE TO (c): 420.0
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1960 to July 26 61 and last saw ~~her~~ him alive on July 26 61
Death occurred at 3:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. Neusbaum (Degree or title) MD
22b. ADDRESS: 3707 Grandel Sq
22c. DATE SIGNED: 7-27-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: July 29, 1961
23c. NAME OF CEMETERY OR CREMATORY: New Picker Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS: BEIDERWIEDEN F.H.INC., 1936 ST. LOUIS AVE.
25. DATE RECD. BY LOCAL REG.: JUL 28 1961
26. REGISTRAR'S SIGNATURE: Noal Smith M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED
S
BY AFFIDAVIT OF DOCUMENT

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 Homer W. Fritz

Licensed Embalmer No. 3882

P. O. Address St. Louis

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.