

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-039388

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

318

1003

9297

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		a. STATE <b>Missouri</b>	b. COUNTY <b>St. Louis</b>
Length of stay in 1b <b>4 wks.</b>		c. CITY OR TOWN <b>Maplewood</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>7403 Elm Ave.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>Ida</b>	Middle	Last <b>Wiggins</b>	4. DATE OF DEATH	Month <b>Oct.</b>	Day <b>6th</b>	Year <b>1961</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-13-1874</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Melrose, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Michael Bouquet</b>	13b. MOTHER'S MAIDEN NAME <b>Fredricka Ossenfort</b>	14. NAME OF HUSBAND OR WIFE <b>Walter M. Wiggins</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Emiline Kindorf, Eureka Sps. Ark.</b>	Address <b>Rt #1</b>
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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 <b>2 months</b>
IMMEDIATE CAUSE (a) <b>Adeno-carcinoma of the rectum</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Acute peritonitis</b>	
	DUE TO (c) <b>Diverticulosis of the large bowel</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>154X</b>	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.) <b>154X</b>
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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 <b>St. Louis</b>	COUNTY <b>St. Louis Co.</b>	STATE <b>Mo.</b>
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21. I attended the deceased from <b>August 19, 1961</b> to <b>Oct 6, 1961</b> and last saw her <b>alive</b> on <b>Oct 6, 1961</b>	Death occurred at <b>4 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Vincent F Townsend MD</b>	(Degree or title)	22b. ADDRESS <b>3101 Suttin Ave Maplewood 17 Mo</b>	22c. DATE SIGNED <b>10-7-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-9-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>	(State)
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24. FUNERAL DIRECTOR <b>JAY B. SMITH, Maplewood, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>OCT 9 1961</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Malvin Darteau

Licensed Embalmer No. 4903

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.