

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JAN 5 1962

-61-047030

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12075 STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

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 ST. LOUIS		Length of stay in 1b		a. STATE MISSOURI		b. COUNTY ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DE PAUL HOSP			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN BEL-RIDGE 21		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
					d. STREET ADDRESS 3525 MEDORA		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARK CHARLES WOLL				4. DATE OF DEATH Month Day Year DECEMBER 24-1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-24-61	
						9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 19 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			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 JOHN EDWARD WOLL			13b. MOTHER'S MAIDEN NAME BEATRICE NEUMANN		14. NAME OF HUSBAND OR WIFE NONE		
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.		17. INFORMANT Address Mrs. John E. Woll 3525 MEDORA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocardiogram</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>762.5</u>							INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
20c. TIME OF INJURY Hour s.m. p.m.		Month, Day, Year					
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 12-24-61 to 12-24-61 and last saw her/him alive on 12-24-61 Death occurred at 9:45 PM m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>[Signature]</i> (Degree (title) M.D.				22b. ADDRESS 1453 McLaran Ave.		22c. DATE SIGNED 12-26-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-25-61	23c. NAME OF CEMETERY OR CREMATORY Forest Lawn		23d. LOCATION (City, town, or county) (State) St. Paul, Minn.		
24. FUNERAL DIRECTOR White-Mullen 118 N. Florissant Rd. Ferg.				25. DATE RECD. BY LOCAL REG. DEC 25 1961		26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M.D.	

Mr. C. Belle

8809 Grandfellow. Bldg.

Carlson Funeral Home
St. Paul, Wisconsin.

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 Richard K. Larson

Licensed Embalmer No. 3395

P. O. Address St. Louis 357

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.