

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013291
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2906

FILED MAR 26 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b <u>4 Wks.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> COUNTY <u>MADISON</u>		c. CITY OR TOWN <u>GRANITE CITY</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>JEWISH HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>2317 WATERMAN AVE.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>OTHELIA</u> Middle <u>WAGNER</u> Last <u>WAGNER</u>			4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1962</u>								
5. SEX <u>FEMALE</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>4-23-02</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done in most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>PERU, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>					
13a. FATHER'S NAME <u>JOHN SEPPI</u>			13b. MOTHER'S MAIDEN NAME <u>MARIE QUANTI</u>			14. NAME OF HUSBAND OR WIFE <u>ELMER 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>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Elmer Wagner</u>		Address <u>2317 Waterman Ave Granite City, Ill</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>Hepatic Coma</u>								<u>2 days</u>			
DUE TO (b) <u>Esophageal Varices</u>								<u>1 year</u>			
DUE TO (c) <u>Cirrhosis of Liver</u>								<u>5 years</u>			
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 checked="" type="checkbox"/> No <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									
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>2/24/62</u> to <u>3/12/62</u> and last saw her/him alive on <u>3/12/62</u> Death occurred at <u>4:25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>Carle Hufsch M.D.</u>				22b. ADDRESS <u>457 N. Kings Highway</u>				22c. DATE SIGNED <u>3/10/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-12-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET HILL</u>		23d. LOCATION (City, town, or county) (State) <u>EDWARDSVILLE, ILL.</u>					
24. FUNERAL DIRECTOR <u>MERCER FUNERAL HOME</u>				25. DATE RECD. BY LOCAL REG. <u>GRANITE CITY ILLINOIS</u>		26. REGISTRAR'S SIGNATURE <u>Roal Smith M.D.</u>					

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 Christen P. Hellesmo

Licensed Embalmer No. 5016

P. O. Address Granite City, Illinois

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.