

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-043808
STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 285

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED
1 6928
2 2929
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4 1
5 2
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7 0
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9 331X
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12 90-0
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DATE AMENDED
INSTEAD OF
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FILED NOV 27 1962		1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>St. Charles</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>917 So. Fourth St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>515 Clay St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wilhelmina</u> Middle <u>"Minnie"</u> Last <u>Mager</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 22, 1884</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>29</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>St. Charles, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Ferdinand Ernst</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Dralemann</u>	
14. NAME OF HUSBAND OR WIFE <u>Frank Mager</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>Mrs. Mary F. Wilhelm, St. Charles, Mo.</u>		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>Cerebral vascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive and Arteriosclerotic Cardiovascular Disease</u> 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 INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>Unknown</u>		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.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u> <u> </u> <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.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>July 28, 1962</u> to <u>November 21, 1962</u> and last saw her <u>alive on Nov. 21, 1962</u> Death occurred at <u>2:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Don Z. Randall, M.D.</u>			22b. ADDRESS <u>220 S. 6th St. Charles, Mo.</u>		22c. DATE SIGNED <u>Nov 24 1962</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 24, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Charles, Mo.</u>
24. FUNERAL DIRECTOR <u>H.C. Dallmeyer & Sons, St. Charles, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-23-62</u>		26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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, -38

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Charles J. Macke

Licensed Embalmer No.

4530

P. O. Address

St. Charles, 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.