

FILED MAR 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6923

State File No.

1808

#63756

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN St. Louis, Mo.)		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1				d. STREET ADDRESS (If rural, give location) 76 3540 Arkansas			
3. NAME OF DECEASED (Type or Print)		a. (First) GEORGE		b. (Middle)		c. (Last) WOTLI	
4. DATE OF DEATH		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 1/16/1891		9. AGE (In years, last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City of St. Louis		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME George Wotli		13b. MOTHER'S MAIDEN NAME Mary Tenebven		14. NAME OF HUSBAND OR WIFE Rose Wotli	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY (If yes, give no. or date described) XXXX		17. INFORMANT'S SIGNATURE OR NAME Rose Wotli		ADDRESS 3540 Arkansas	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Squamous cell Ca right tonsil with metastases to submandibular ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last: DUE TO (b) and cervical areas DUE TO (c) and cervical areas II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 145 X		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 1/12/50 , 19 50 , to 2/22/50 , 19 50 , that I last saw the deceased alive on 2/22/50 , 19 50 , and that death occurred at 4:21 PM , from the causes and on the date stated above.							
23a. SIGNATURE C. McAfee (Degree or title) M.D.				23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 2/23/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/25/50		24c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery,		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE RECD BY LOCAL REG. FEB 24 1950		REGISTRAR'S SIGNATURE J. B. Fasater		25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Pellus H.F.C., 3634 Anovis ADDRESS			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address St Louis, 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 this body is not embalmed, fact should be so stated above.