

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6937**

FILED MAR 4 1954

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1412**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis	
c. LENGTH OF STAY (in this place) 33 Years		d. STREET ADDRESS (If rural, give location) 1508 Hebert Street, 7, 26	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1508 Hebert Street, 7,			

3. NAME OF DECEASED (Type or Print)	a. (First) AUGUST	b. (Middle)	c. (Last) WAHLBRINK	4. DATE OF DEATH (Month) (Day) (Year) February 18th, 1954
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 23rd, 1872	9. AGE (in years last birthday) 81

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Columbia Brewing Co.	11. BIRTHPLACE (City and State or Foreign Country) Westphaelen, Germany	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Wahlbrink	13b. MOTHER'S MAIDEN NAME Dina Sophia Fangermeier	14. NAME OF HUSBAND OR WIFE Late Pauline Wahlbrink
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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) No None	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Raymond Wahlbrink, 1038 Veronica Avenue, 15	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cardio vascular disease		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Dog gouge in left foot DUE TO (c)		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 4221
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22. I hereby certify that I attended the deceased from **1-14, 1953**, to **2-13, 1954**, that I last saw the deceased alive on **2-9, 1954**, and that death occurred at **7:05 PM**, from the causes and on the date stated above.

23a. SIGNATURE J. E. Mohr M.D.	(Degree or title)	23b. ADDRESS 4110 W. Flannigan ave 2-1354	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/16/54	24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri.
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DATE REC'D BY LOCAL REG. FEB 15 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	FUNERAL DIRECTOR'S SIGNATURE GALVIN F. FEUTZ	ADDRESS 5228 Natural Bridge Blvd. St. Louis, 15, Mo.
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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

Royce C. Zindler

Licensed Embalmer No.

4275

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.