

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38998

State File No.

10433

BIRTH NO. 83988-55 REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No.

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>ST. LOUIS, MISSOURI</u> township) | | c. CITY OR TOWN <u>St. Louis</u> | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL.</u> | | e. STREET ADDRESS (If rural, give location) <u>22 2642a Hickory St.</u> | |
| 3. NAME OF DECEASED a. (First) <u>BABY BOY</u> (Type or Print) | | b. (Middle) _____ c. (Last) <u>WAGNER</u> | |
| 4. DATE OF DEATH (Month) (Day) (Year) <u>NOVEMBER 9, 1955.</u> | | 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u> | | 8. DATE OF BIRTH <u>NOV. 9, 1955</u> | |
| 9. AGE (In years last birthday) _____ IF UNDER 1 YEAR _____ IF UNDER 1 HR. _____ | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) <u>CITY HOSPITAL #1, St. Louis, Mo.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13a. FATHER'S NAME <u>CHARLES WAGNER</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>MARTHA RICHARDSON</u> | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Martha Wagner</u> | | ADDRESS <u>2642a Hickory St.</u> | |
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Immaturity</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>776X</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>774X</u> | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | |
| 21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____ | | 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 <u>11-9-</u> , 19 <u>55</u> , to <u>NOVEMBER 9,</u> 19 <u>55</u> , that I last saw the deceased alive on <u>11-9</u> , 19 <u>55</u> , and that death occurred at <u>7:00a</u> m., from the causes and on the date stated above. | |
| 23a. SIGNATURE <u>Lon B. Klich, M.D.</u> (Degree or title) _____ | | 23b. ADDRESS <u>1515 LAFAYETTE AVE.</u> | |
| 23c. DATE SIGNED <u>11-9-55.</u> | | 24a. BURIAL, CREMATION, REMOVAL (Specify) _____ 24b. DATE <u>11-30-55</u> | |
| 24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | |
| DATE REC'D BY LOCAL REG. <u>NOV 30 1955</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | ADDRESS <u>Howard - Her Mortuary Service</u> | |

(Licensed Embalmer's Statement on Reverse Side) NUMBER AVE.

St. Louis 13, Mo.

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

No. 300
10-48

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.....

Licensed Embalmer No.....

P. O. Address.....

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.