

## STANDARD CERTIFICATE OF DEATH

26983

State File No. ....

FILED AUG 7 1957

BIRTH NO. ....		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>590</u>		Registrar's No. <u>1798</u>			
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				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 township) <u>Rock Hill</u>		c. LENGTH OF STAY (in this place) <u>3 mos.</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Rock Hill Rest Home</u>				e. STREET ADDRESS (If rural, give location) <u>7157 D 4537 Nebraska Ave</u>					
3. NAME OF DECEASED (Type or Print) <u>ROSE</u>		a. (First)		b. (Middle) <u>WUNDERLI</u>		c. (Last)			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>5-26-1870</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>87</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Emil Reppold</u>		13b. MOTHER'S MAIDEN NAME <u>Emalie Harolt</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>499-26-9458</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lellie Beck</u>		ADDRESS <u>4537 Nebraska Ave</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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arterio-sclerotic heart disease</u>				ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) _____					
DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral Hemiplegia</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" 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) <u>4200</u>					
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>MAY 25</u> , 19 <u>57</u> , to <u>7-16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-15-57</u> , 19 <u>57</u> , and that death occurred at <u>12:45 Pm.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>A. J. Merkelin M.D.</u>				23b. ADDRESS <u>3509 Poloway</u>		23c. DATE SIGNED <u>7-18-57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7-19-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>		24d. LOCATION (City, town, or county) (State) <u>10160 Gravois Road No</u>			
DATE REC'D BY LOCAL REG. <u>7/18/57</u>		REGISTRAR'S SIGNATURE <u>Herbert B. Romberg</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ziegenhein Bros</u>		ADDRESS <u>6409n Gravois Ave</u>			

(Licensed Embalmers Statement on Reverse Side)

Dr. Merkelin 3507 Potomac St  
 PR 1-1863 1-2-56-7  
 WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *John M. Simpson*

Licensed Embalmer No. *4343*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

STATE OF MISSOURI DEPARTMENT OF HEALTH