

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34431  
STATE FILE NUMBER

FILED SEP 23 1957

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2145

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> COUNTY <i>St. Louis</i>	
b. CITY OR TOWN <i>Webster Groves</i> <small>(If outside corporate limits, give TOWNSHIP only)</small> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Webster Groves</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>BARNES HOSPITAL</i> Length of stay in months <i>15 YEARS</i>		d. STREET ADDRESS <i>517 Atlanta</i> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <i>RALPH PHILLIP WURTZ</i>			4. DATE OF DEATH Month Day Year <i>AUGUST 27, 1957</i>		
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5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 8, 1890</i>	9. AGE (In years last birthday) <i>66</i>	10. UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>machinist</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or country) <i>St. Louis Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Robert E. Wurtz</i>	13b. MOTHER'S MAIDEN NAME <i>Friedricha Meyer</i>	14. NAME OF HUSBAND OR WIFE <i>Marie Catherine Wurtz</i>
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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) <i>no</i>	16. SOCIAL SECURITY NO. <i>492-096580</i>	17. INFORMANT Address <i>Marie Catherine Wurtz 512 Atlanta</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHRONIC PULMONARY EMPHYSEMA</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 YRS.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>5271</i>		19. WAS AUTOPSY PERFORMED? <i>2</i> 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <i>JANUARY 6, 1951</i> to <i>AUGUST 27, 1957</i> and last saw her alive on <i>AUGUST 27, 1957</i> Death occurred at <i>8:35 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>C. J. Nemellia, M.D.</i> (Degree or title)	22b. ADDRESS <i>BARNES HOSPITAL</i>	22c. DATE SIGNED <i>8/2/8/57</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>Aug. 31, 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New St. Marys Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>7901 E. Sarver St. Mo.</i>
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24. FUNERAL DIRECTOR <i>Bull-Campbell Mortuary</i> ADDRESS	25. DATE RECD. BY LOCAL REG. <i>8-28-57</i>	26. REGISTRAR'S SIGNATURE <i>Herbert B. Donohue</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Elmer P. Cadwell* .....

Licensed Embalmer No. *4077* .....

P. O. Address *St. Louis* .....

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.