

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43121

STATE FILE NUMBER

FILED NOV 22 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2794

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 <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sycamore Hills</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Sycamore Hills</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2439 Northland</u> Length of stay in 1b <u>4 PERS</u>		d. STREET ADDRESS <u>2439 Northland</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jewell</u> Middle <u>Henry</u> Last <u>Wild</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1900</u>
9. AGE (In years last birthday) <u>57</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dist. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S. W. Bell Tel.</u>	11. BIRTHPLACE (City and state or country) <u>Oak Grove, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W.W.#1</u>	
16. SOCIAL SECURITY NO. <u>492-07-7429</u>		17. INFORMANT Address <u>Rosemarie Hausmann, 2439 Northland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> DUE TO (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>4/201</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>8 weeks</u>
19. WAS AUTOPSY PERFORMED? 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.)		20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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	
21. I attended the deceased from <u>Sept 9, 1957</u> to <u>Nov 9, 1957</u> and last saw <u>her</u> alive on <u>Nov 9, 1957</u> Death occurred at <u>2105 Caban</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or Attendant) <u>M. A. Decker</u>		22b. ADDRESS <u>9924 St. Charles</u> <u>St. Robert, Mo</u>	
22c. DATE SIGNED <u>11/9/57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>11-11-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Ann, Missouri</u>		23e. STATE <u>Missouri</u>	
24. FUNERAL DIRECTOR <u>Baumann Bros. Inc.</u> <u>2504 Woodson Rd. Overland, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-11-57</u>	
26. REGISTERAR'S SIGNATURE <u>Hebert K. Somberg</u>		27. _____	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
S. 300
1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

APR 21 1958

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 *David C. Gibson*

Licensed Embalmer No. *34*

P. O. Address *Overland*
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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.