Health, Welfare Public Service

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FILED MAR 27 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-012462

STATE FILE NUMBER 2499

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St.Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St.Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Wellston 4301 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 18 Park Lane Hospital — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 27 6334 Ridge Ave. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First: John	Middle: Cleveland	Last: Washaw
4. DATE OF DEATH	Month: February	Day: 27,	Year: 1958
5. SEX: Male 0	6. COLOR OR RACE: White	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] / DIVORCED [ ]	8. DATE OF BIRTH: Nov.9,1890
9. AGE (In years last birthday): 67	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist	10b. KIND OF BUSINESS OR INDUSTRY: Iron Works	11. BIRTHPLACE (City and state or country): St.Louis,Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME: Peter Washaw	13b. MOTHER'S MAIDEN NAME: Josephine Jondreau	14. NAME OF HUSBAND OR WIFE: Agnes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Agnes Washaw, Address: 6334 Ridge Ave.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Emfor ct. — INTERVAL BETWEEN ONSET AND DEATH: 6 MS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Femoral Thrombosis — 3 mo

DUE TO (c) Interstitial Nephritis - Arteriosclerosis — —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 594x

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 2

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 10-57, to 2-27-58 and last saw her/him alive on 2-27-58

Death occurred at 7:42Pm p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. A. Knight MD 0	22b. ADDRESS: 8201 N Broadway	22c. DATE SIGNED: MAR 1 '58
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 3-3-58	23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis,Mo.		
24. FUNERAL DIRECTOR: Albert H.Hoppe, ADDRESS: 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG.: MAR 1 '58	26. REGISTRAR'S SIGNATURE: J Carl Smith MD MJB.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 G W Wilkinson

Licensed Embalmer No. 3573

P. O. Address [illegible]

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.