

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034791
STATE FILE NUMBER

FILED OCT 14 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9123

5. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN Ladue	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS 1350 McCutcheon	

3. NAME OF DECEASED (Type or print) Lillian M. Wachenfeld			4. DATE OF DEATH Sept. 20, 1958		
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5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1893	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Joseph Sauers	13b. MOTHER'S MAIDEN NAME Nellie McLaughin	14. NAME OF HUSBAND OR WIFE Dr. Carl H. Wachenfeld
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Herbert C. Peterson, 7127 Forsyth Blvd.
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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>Carcinoma secundary</i> DUE TO (b) <i>& Carcinoma of Uterus Uterus</i> DUE TO (c) <i>181.0</i>		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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
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21. I attended the deceased from *Feb 15, 1957* to *Sept 20, 1958* and last saw her alive on *Sept 20, 1958*
Death occurred at *7:20 PM* on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Dr. L. H. ... M.D.</i>	22b. ADDRESS <i>Deaconess Hospital</i>	22c. DATE SIGNED SEP 29 '58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 23, 1958	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR <i>Arthur J. Newelly</i>	ADDRESS 3810 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. SEP 22 '58	26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Francis Williams*

Licensed Embalmer No. *3565*
P. O. Address *3840 Linde*

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.