

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003655

STATE FILE NUMBER

794

1959 FEB 10

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

300  
-57  
0  
22

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</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>5141 ROSA</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>7027 ADDRESS 5141 ROSA</i>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>FREDERICK (FRED) WOCHOLE</i>			4. DATE OF DEATH Month Day Year <i>JAN 22 1959</i>		
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG 14, 1884</i>	9. AGE (In years last birthday) <i>74</i>	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) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FREIGHT HANDLER</i>	11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13a. FATHER'S NAME <i>EDWARD WOCHOLE</i>		13b. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i>		14. NAME OF HUSBAND OR WIFE <i>DECEASED</i>	
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.	17. INFORMANT Address <i>FLORA REISERT 5141 ROSA</i>		

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>Cardiac Failure Hypostatic Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Agent episode</i>	
	DUE TO (c) <i>Cardiovascular accident 4221</i>	<i>Oct 59</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Croster Surgery 6 months ago</i>		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 <i>Oct 5 10:30</i> to <i>Jan 22 59</i> and last saw him alive on <i>Jan 22 59</i> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <i>Edward Wochole MD</i>	22b. ADDRESS <i>3720 Washington Pl</i>	22c. DATE SIGNED <i>1-23-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>1/26/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL PARK</i>
		23d. LOCATION (City, town, or county) (State) <i>AFFTON, Mo.</i>

24. FUNERAL DIRECTOR ADDRESS <i>J L ZIEGENHEIN &amp; SONS 7027 GRAVOIS</i>	25. DATE RECD. BY LOCAL REG. <i>JAN 23 '59</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>
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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 *N. Gold E. Bay* .....

Licensed Embalmer No. *4863* .....

P. O. Address *Ht. 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.