

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-017573  
STATE FILE NUMBER

FILED VS APR 22 1960 317

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1077

ENDED

|                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. LOUIS</b>                                                                                                                                                                                        |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>                |                                                                                                                                                                                 |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WEBSTER GROVES</b>                                                                                                                                                |                                                                                                           | Length of stay in 1b <b>YEARS</b>                                                                                                                           | c. CITY OR TOWN <b>WEBSTER GROVES</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                         |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>+35 OAKWOOD</b>                                                                                                                                         |                                                                                                           | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                           | d. STREET ADDRESS (If outside, give location) <b>435 OAKWOOD</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                             |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>ELIZABETH JANE WILSON</b>                                                                                                                                                  |                                                                                                           |                                                                                                                                                             | 4. DATE OF DEATH Month Day Year<br><b>MARCH 29 1960</b>                                                                                                                         |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                | 6. COLOR OR RACE<br><b>WHITE</b>                                                                          | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/22/1914</b>                                                                                                                                            |
| 9. AGE (last birthday)<br><b>45</b>                                                                                                                                                                                                    |                                                                                                           | IF UNDER 1 YEAR Months Days                                                                                                                                 | IF UNDER 24 HR Hours Min.                                                                                                                                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>                                                                                                                             |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                                                                                         | 11. BIRTHPLACE (City and state or country)<br><b>ST. LOUIS MO</b>                                                                                                               |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A</b>                                                                                                                                                                                            |                                                                                                           | 13a. FATHER'S NAME<br><b>OLIVER CHAPMAN</b>                                                                                                                 |                                                                                                                                                                                 |
| 13b. MOTHER'S MAIDEN NAME<br><b>MAE WIEDMER</b>                                                                                                                                                                                        |                                                                                                           | 14. NAME OF HUSBAND OR WIFE<br><b>LOUIS J WILSON</b>                                                                                                        |                                                                                                                                                                                 |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                  |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>unk.</b>                                                                                                                      | 17. INFORMANT Address<br><b>L.J. Wilson 435 OAKWOOD</b>                                                                                                                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cystadenoma, left ovary</b>                                                                         |                                                                                                           |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>                                                                                                                              |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                                                                                      |                                                                                                           |                                                                                                                                                             | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>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 <b>March 1955</b> to <b>present</b> and last saw her/him alive on <b>3-27-60</b><br>Death occurred at <b>8 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                 |
| 22a. SIGNATURE (Degree or title)<br><b>Robert C. Kugelend MD</b>                                                                                                                                                                       |                                                                                                           | 22b. ADDRESS<br><b>14 Fourth with Clayton 5, Mo</b>                                                                                                         | 22c. DATE SIGNED<br><b>3-31-60</b>                                                                                                                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                             | 23b. DATE<br><b>APRIL 1, 1960</b>                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RESURRECTION SEM</b>                                                                                               | 23d. LOCATION (City, town, or county) (State)<br><b>ST. LOUIS COUNTY MO</b>                                                                                                     |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>STOCK MORTUARY 889 S BRENTWOOD CLAYTON</b>                                                                                                                                                          |                                                                                                           | 25. DATE RECD. BY LOCAL REG.<br><b>3-31-60</b>                                                                                                              | 26. REGISTRAR'S SIGNATURE<br><b>John C. Murphy Md.</b>                                                                                                                          |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

**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

*Paul A. Wachter*

Licensed Embalmer No. 4787

P. O. Address *St 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.