

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS MAY 6 1960

=60-017822

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1454 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		c. CITY OR TOWN <u>Berkeley</u>	
Length of stay in lb		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>Normandy Osteopathic Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>8268 January</u>	
Inside Hospital or Institution Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Vernetta</u> Middle <u>E.</u> Last <u>Waller</u>			4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>60</u>			
5. SEX <u>Female</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>3-15-96</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Sioux City, Iowa</u>		
13a. FATHER'S NAME <u>George Schueler</u>		13b. MOTHER'S MAIDEN NAME <u>Stella Spore</u>		14. NAME OF HUSBAND OR <u>Elmore Waller</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. D. Sheridan 8268 January Ave.</u>	
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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) <u>Cerebral infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Route</u> <u>5 yr</u> <u>5 yr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>			
DUE TO (c) <u>Arteriosclerosis</u>			
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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 a.m. p.m. Month, Day, Year			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>January 1955</u> to <u>4-30-60</u> and last saw her/him alive on <u>4-20-60</u> Death occurred at <u>9:25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>[Address]</u>	22c. DATE SIGNED <u>4-30-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Home Burial</u>	23b. DATE <u>5/4/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.</u>	25. DATE RECD. BY LOCAL REG. <u>5-3-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

MS NOV 28 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *J. M. Pister*

Licensed Embalmer No. 3980

P. O. Address St. Louis

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.