

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025127

FILED VS JUN 27 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6099

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. Louis		Length of stay in 1b		c. CITY OR TOWN ST. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. ANTHONY HOSP			Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		d. STREET ADDRESS (If outside, give location) 2841^{1/2} S. 13TH		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last ELSIE M. WRABLIK				4. DATE OF DEATH Month Day Year JUNE 13 1960					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11-8-1892		9. AGE (last birthday) 67 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) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST. Louis Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME HENRY DIERKES			13b. MOTHER'S MAIDEN NAME KATIE SICKING			14. NAME OF HUSBAND OR WIFE JOSEPH WRABLIK (dec'd)			
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. None		17. INFORMANT Address ELVIRA WRABLIK 2841^{1/2} S 13TH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterial hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arterial sclerosis DUE TO (c) - 331X							INTERVAL BETWEEN ONSET AND DEATH 3 days		
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 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 June 1 - 60 to June 12/60 and last saw her/him alive on June 3/60 Death occurred at 12 25th on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE St J Byrne M.D. (Degree or title)				22b. ADDRESS 2752^{1/2} Cherokee			22c. DATE SIGNED 6-14-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE JUNE 15, 1960		23c. NAME OF CEMETERY OR CREMATORY RESURRECTION Cem.		23d. LOCATION (City, town, or county) (State) ST. Louis Mo.			
24. FUNERAL DIRECTOR Thomas Katis 2906 Annonis				25. DATE RECD. BY LOCAL REG. JUN 15 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 James O. White

Licensed Embalmer No. 4347

P. O. Address 2906 L

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.