

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025243

FILED VS JUL 7 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1858 STATE FILE NUMBER

DED

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>CLAYTON</u>			Length of stay in 1b		c. CITY OR TOWN <u>WEBSTER GROVES</u>		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>COUNTY HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1001 E. BIG BEND</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Don</u> Middle <u>Louis</u> Last <u>Wambaugh</u>				4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>60</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 20 1892</u>	
9. AGE (last birthday) <u>68</u>		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) <u>MAINTENANCE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRIC</u>		11. BIRTHPLACE (City and state or country) <u>GALVESTON, TEXAS</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>MAHLON WAMBAUGH</u>			13b. MOTHER'S MAIDEN NAME <u>ANNA KOEHLER</u>			14. NAME OF HUSBAND OR WIFE <u>BARBARA WAMBAUGH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>YES WW #1</u>			16. SOCIAL SECURITY NO. <u>498-01-1865A</u>		17. INFORMANT <u>EDMUND WAMBAUGH 601 WESTGATE</u>		
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</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 type="checkbox"/> N. <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 <u>6-12-60</u> to <u>6-17-60</u> and last saw ^{her} him alive on <u>6-17-60</u> Death occurred at <u>5:40 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Marshall Jung MD</u>				22b. ADDRESS <u>601 So. Brentwood</u>		22c. DATE SIGNED <u>6/17/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6-20-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>VAL HALLA</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. Mo.</u>	
24. FUNERAL DIRECTOR <u>C.R. LUPTON & SONS 2233 DELMAR</u>				25. DATE RECD. BY LOCAL REG. <u>6-18-60</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Clarence H. D.

Licensed Embalmer No. *4014*

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.