

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028955

FILED VS AUG 8 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 737E STATE FILE NUMBER

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b <u>68 YEARS</u>	c. CITY OR TOWN <u>ST. LOUIS</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>5233 GILMORE AVE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5233 GILMORE AVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRED C.</u> Middle <u>WUELLNER</u> Last			4. DATE OF DEATH Month <u>JULY</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>MALE</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>DEC 18 1878</u>	9. AGE (last birthday) <u>81 YRS</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CABLE SPLICER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TELEPHONE CO.</u>	11. BIRTHPLACE (City and state or country) <u>MINDEN, GERMANY</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>FRED KUHLMAN</u>		13b. MOTHER'S MAIDEN NAME <u>SOPHIE HOSTETTER</u>		14. NAME OF HUSBAND OR WIFE <u>MARY WUELLNER</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>HELEN KUHLMAN 5233 GILMORE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH AS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalized</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs?</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		
		<u>450.0</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"/> 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 <u>6:10:50</u> to <u>7:23:60</u> and last saw ^{him} alive on <u>7:14:60</u> Death occurred at <u>11:30P.m</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Charles Jost M.D.</u>		(Degree or title)	22b. ADDRESS <u>6000 W Florissant</u>		22c. DATE SIGNED <u>7:24:60</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>BURIAL</u>	23b. DATE <u>JULY 26, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS</u>	STATE <u>MO.</u>		
24. FUNERAL DIRECTOR <u>Ched Meyer & Sons</u>		ADDRESS <u>3934 N. 20 ST.</u>	25. DATE RECD. BY LOCAL REG. <u>JUL 25 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 3749

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.