MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-006997
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1153

FILED VS FEB 20 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 3645 Wyoming
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3645 Wyoming
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First NORMAN Middle H Last WACKER
4. DATE OF DEATH: Month February Day 2 Year 1961
5. SEX: male
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/11/1896
9. AGE (last birthday): 64
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): Western Union
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Edward Wacker
13b. MOTHER'S MAIDEN NAME: Sophia Hild
14. NAME OF HUSBAND OR WIFE: Mildred
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW-I
17. INFORMANT: Mildred Wacker Address: 3645 Wyoming

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Essential Hypertension
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Immediate death
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 420.1
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Jan 1960 to Feb 2/1961 and last saw him alive on Feb 2, 1961
Death occurred at 5:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Ralph Berg MD
22b. ADDRESS: 3203 S Grand
22c. DATE SIGNED: 2/4/61
23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 2/6/1961
23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
23d. LOCATION (City, town, or county) (State): Affton, Mo.
24. FUNERAL DIRECTOR: John L Ziegenhein & Sons ADDRESS: 7027 Gravois
25. DATE RECD. BY LOCAL REG.: FEB 6 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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 G. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.