

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5099 STATE FILE NUMBER 61-018781

1. PLACE OF DEATH a. COUNTY		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>St. Louis</u>		Length of stay in 1b <u>6 Days</u>	c. CITY OR TOWN <u>St. Louis Co.</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>Park Lane Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10934 Three Court Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>WACKMAN</u> Last <u>ALTHAGE</u>			4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1961</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>Nov. 20, 1896</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.
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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>Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>George Wackman</u>	13b. MOTHER'S MAIDEN NAME <u>Clara Blazek</u>	14. NAME OF HUSBAND OR WIFE <u>Walter W. Althage</u>
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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 <u>Mrs. Claire Louise Zimmer 10934 Three Court Dr.</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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Hypertension 200-60</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Diabetes + XXXX</u>	
DUE TO (b)	<u>coronary occlusion</u>	
DUE TO (c)	<u>Permanent arrhythmia</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
<u>as stated above 260x</u>	

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.) <u>none</u>
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20c. TIME OF INJURY <u>none</u>	Month, Day, Year
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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.) <u>none</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY	STATE
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21. I attended the deceased from <u>7-1-58</u> to <u>5-30-61</u> and last saw her alive on <u>5-29-61</u> Death occurred at <u>12:30 am 5-30-61</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>M. F. Namm, M.D.</u>	(Degree or title)	22b. ADDRESS <u>2739 Weber St. St. Louis 8, Mo.</u>	22c. DATE SIGNED <u>5/31/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>June 2, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>
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24. FUNERAL DIRECTOR <u>Alexander &amp; Sons 6175 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 31 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF  
ITEM NO.

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

*Jos. E. McCulloch*

Licensed Embalmer No. 2760

P. O. Address 6150 Rd

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.