

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031498

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2483

FILED SEP 13 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY CASS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO.		c. CITY OR TOWN BEARDSTOWN	
Length of stay in 1b 10 DAYS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMIN. HOSPITAL		d. STREET ADDRESS 1108 E. 7th STREET (If outside, give location)	
3. NAME OF DECEASED (Type or print) First RALPH Middle P. Last WOLFMILLER		4. DATE OF DEATH Month 9 Day 3 Year 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-15-96
10a. USUAL OCCUPATION (Give kind of work done most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD - C.B. RR	9. AGE (last birthday) 65 YEARS
11. BIRTHPLACE (City and state or country) CORNING, ARK.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME CHRIS WOLFMILLER		13b. MOTHER'S MAIDEN NAME ELIZABETH CRALION	
14. NAME OF HUSBAND OR WIFE MAUDE WOLFMILLER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MAUDE WOLFMILLER (Wife) Address 1108 E. 7th Street, Beardstown, Ill.	
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) HYDROPNEUMOTHORAX			6 WEEKS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARDIAC DECOMPENSATION			2 YEARS
DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE			5 YEARS
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 checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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. VA attended the deceased from 8-24-61 to 9-3-61 Death occurred at 10:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John Jusionis (Doctor or title) John Jusionis, M.D.		22b. ADDRESS VET. ADM. HOSP., JEFF. BRKS., MO.	22c. DATE SIGNED 9-3-61
23a. BURIAL CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 9/7/61	23c. NAME OF CEMETERY OR CREMATORY CITY	23d. LOCATION (City, town, or county) (State) Beardstown Ill
24. FUNERAL DIRECTOR Frank J. Cline ADDRESS Beardstown	25. DATE RECD. BY LOCAL REG. 9-4-61	26. REGISTRAR'S SIGNATURE John B. Murphy M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.