549

REC'D MAY 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1003

12735
Do not use this space.

1. PLACE OF DEATH

(a) County..... | Registration District No.....

(b) Township..... Primary Registration District No..... Registered No. 3077

(c) City or ST. LOUIS, MO. (d) Street No. ST. ANTHONY'S HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 38 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME HELENA WIESE

(a) Residence, No. 4153a HUMPHREY St. 16
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
F.	W.	MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF FREDERICK

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 5, 1883

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	1	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) FEB. 27, 1939

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) PADERBORN, ILL.

FATHER

13. NAME HENRY BUSS

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS, MO.

MOTHER

15. MAIDEN NAME MAGADELYN KAISER

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GERMANY

17. INFORMANT Fred O. Wiese Jr.
(ADDRESS) 4162 Wyoming St.

18. BURIAL, CREMATION, OR REMOVAL
PLACE NEW SS PETER-PAUL 4/3/39 19

19. FUNERAL DIRECTOR (NAME) OSCAR J. HOFFMEISTER
(ADDRESS) 4016 CHIPPEWA ST.

20. FILED APR 1 1939 19 J. F. Bredech
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-30-39 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 8 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Septicemia following severe lacerations of Right Hand and Wrist (Manufacturing) suffered while deceased at work became infected	

Other contributory causes of importance:
Lived at the Residence of her Sister 4153a Humphrey on Feb 27-1939 at about 10 A.M.

Name of operation ..... Date of ..... NO

What test confirmed diagnosis? ..... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 2-27, 1939
Where did injury occur? St. Louis
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home or in public place. Home

Manner of injury .....

Nature of injury ..... NO

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Joseph H. Leeman, M. D.

(Address) Bergman Ave

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X 16605

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....Edwin H. Leibinger

Licensed Embalmer No.....4049

P. O. Address.....4016 Ogden

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 this body is not embalmed, above space should be left blank.