

REPRODUCING BACK INK—MAKE 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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23889

State File No.

6162

Registration District No. 791

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Month
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Louise Wissmann 256

8. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Gilbert Wissmann 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased October 17 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 8 24 hr. min.

9. Birthplace House Spring Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name John Leight

13. Birthplace House Spring Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Gilbert Wissmann

(b) Address 4004 Cote Brilliante

17. (a) Burial (b) Date thereof July 13 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Donse Burial Park

18. (a) Signature of funeral director: Wickmann-Narral

(b) Address 1905 Union Blvd.

19. (a) JUL 12 1939 (b) J. B. Bruders
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 4004 Cote Brilliante
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Months July day 11
year 1939 hour 8 25 minute P. M.

21. I hereby certify that I attended the deceased from May 30th
1939, to July 11th, 1939
that I last saw her alive on July 11th
and that death occurred on the date and hour stated above.

Immediate cause of death
General Peritonitis with
Intestinal Obstruction
Due to Perforation of appendix
with Abscess Formation

Due to _____
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Ganglions appendix
in Abdominal Cavity
Of autopsy None

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature A. J. Lettinger (M. D. or other) MD

Address 2745 N Grand Date signed 7/12/39

2745 N. Grand 1-3

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 Warren A. Carver

Licensed Embalmer No. 3534

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