

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.

**JUN 6 1940**  
Registration District No. **791**

Primary Registration District No. **1003**

**1. PLACE OF DEATH:**  
(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: St. Luke's Hospital  
(d) Length of stay: In hospital or institution 18 days  
In this community 22 1/2 years, months or days

**3. (a) PRINT FULL NAME** CLARA MARGARET WETZEL  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_  
**4. Sex** F **5. Color or race** W  
**6. (b) Name of husband or wife** ITAROLO **6. (a) Single, widowed, married, divorced**  
**6. (c) Age of husband or wife if alive** 33 years  
**7. Birth date of deceased** APR 30 1909  
(Month) (Day) (Year)

**8. AGE:** Years 30 Months 11 Days 25 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace** RUMANIA (City, town, or county) ILL. (State or foreign country)

**10. Usual occupation** HOUSE WIFE

**11. Industry or business** \_\_\_\_\_

**MOTHER**  
**12. Name** LOUIS WETZEL  
**13. Birthplace** LEH... (City, town, or county) (State or foreign country)

**14. Maiden name** LENA KUNSKEL  
**15. Birthplace** RUMANIA (City, town, or county) (State or foreign country)

**16. (a) Informant's own signature** St. Luke's Records  
**(b) Address** 5535 Helmer

**17. (a) Removal** (Burial, cremation, or removal) Removal **(b) Date thereof** 4/26/40  
(Month) (Day) (Year)

**(c) Place: burial or cremation** Tray Ill.  
**(d) Signature of funeral director** Edward...  
**(b) Address** Tray Ill.

**19. (a)** 4/26/40 **(b)** J. J. ...  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis 15  
(d) Street No. 4229 L. 38th  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month April day 25th year 1940 hour 11 minute 15 P. M.  
**21. I hereby certify that I attended the deceased from** April 5th, 1940, to April 25th, 1940, that I last saw her alive on April 25th, 1940, and that death occurred on the date and hour stated above.

**Immediate cause of death** Acute Ulcerative Colitis **Duration** 12 da  
**Due to** Nephritis - acute with uraemia. **10 da**  
**Due to** non-purulent **139**  
**Other conditions** (Include pregnancy within 3 months of death) \_\_\_\_\_

**Major findings:** Cystic Cercaria  
**Of operations** \_\_\_\_\_  
**Of autopsy:** Acute Ulcerative Colitis  
Acute Nephritis.

**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? 844  
(e) Means of injury \_\_\_\_\_  
**23. Signature** Robert L. Drury M.D. (M. D. certifier) M.D.  
**Address** 3548 So. Grand **Date signed** 4/26/40  
St. Louis Mo.

3770

3770

---

---

**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.....

*Jewel Edwards*

Licensed Embalmer No. *3548*

P. O. Address *Troy Ill.*

**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.**