

No. 2
4-12-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Re 34 35

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39798**

Registration District No. **784**

Primary Registration District No. **111**

Registrar's No. **2167**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Mathilda M. Wedekind

3. (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 August Wedekind

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Nov. 14 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>0</u>	<u>2</u>	hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

12. Name Daniel Mueller

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Joeckel

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

16. (a) Informant August Wedekind

(b) Address 1818a Ann Ave St. Louis Mo

17. (a) Burial (b) Date thereof 11-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jes Peres Cem.

18. (a) Signature of funeral director Louise H. Bopp Inc.

(b) Address 131 W. Argonne Dr Kirkwood Mo

19. (a) NOV 16 1940 (b) H. R. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1818a Ann Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November Day 16
year 1940 hour 12 minute 05 A. M.

21. I hereby certify that I attended the deceased from Nov 16 1940 to Nov 16 1940
that I last saw her alive on Nov 15 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Post-operative shock (exsanguinatory)

Due to _____

Due to Cerebral aneurysm of left middle cerebral artery

Other conditions gall stones, benign paroxysmal positional vertigo, coronary atherosclerosis

Major findings: Of operations 4/6/1

Of autopsy _____

Duration 36 hours

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature H. R. Meyer (M. D. or other) _____
Address 131 W. Argonne Dr, Kirkwood, Mo Date signed 11/16/40

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

Louis H. Bagg

Registered Apprentice No.

working under my personal supervision.

Signed

Louis H. Bagg

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.