

No. 2
-12-45
-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **9770**

FILED NOV 25 1946
Missouri Death No. **319**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis**

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

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

(d) Length of stay: In hospital or institution **28 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Carl G. Werscheid**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **male**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Geneva**

6. (c) Age of husband or wife if alive **52** years

7. Birth date of deceased **Sept. 17, 1889**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	57	1	27	hr. _____ min.

9. Birthplace **Beardstown Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Steel Engineer**

11. Industry or business _____

MOTHER FATHER

12. Name **Joseph Werscheid**

13. Birthplace **Beardstown Ill.**
(City, town, or county) (State or foreign country)

14. Maiden name **Sophia Jamison**

15. Birthplace **Beardstown Ill.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Geneva Werscheid**

(b) Address **7410 Richmond Pl.**

17. (a) **burial** (Burial, cremation, or removal)

(b) Date thereof **Nov. 16, 1946**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Lebanon Cem.**

18. (a) Signature of funeral director **Jay B. Smith**

(b) Address **7456 Manchester Ave.**

19. (a) **NOV 15 1946** (Date received local registrar)

(b) *[Signature]* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **Maplewood**
(If outside city or town limits, write "RURAL")

(d) Street No. **7410 Richmond Pl.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **14th**
year **1946** hour **4** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **Oct 19** to **Nov 14**, 19**46**
that I last saw him alive on **Nov 14**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death
**Mesenteric Thrombosis
inferior mesenteric artery
and Pulmonary embolism**

Duration
24 hrs
24 hrs

Due to _____

Other conditions (Include pregnancy within 3 months of death) **12/27**

Major findings:
Of operations **Adhesions from previous peritonitis**

Of autopsy **Same**

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)

(c) Means of injury _____

23. Signature **E. O. Beckenridge, M.D.** (M.D. or other)

Address **Maplewood Mo** Date signed **11-15-46**

[Handwritten mark]

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 3154

....., Registered Apprentice No.
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3484

P. O. Address 7456 March

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, fact should be so stated above.