

U. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7119**
Registrar's No. **1409**

FILED FEB 24 1948
Registration District No. **1003**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Barnard Free Skin and Ca. Hosp. O
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. Feb 3 1947 - Feb 10, 1947
 (Specify whether _____)

In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
 (c) City or town St. Louis (If outside city or town limits, write "RURAL") 1779
 (d) Street No. 2501 Minnesota Ave (If rural, give location) 9
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME Philip Conrad Wenner
 (b) If veteran, name war _____
 (c) Social Security No. 495 26 8395

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 10
 year 1947 hour 8 6 minute 30 AM.

21. I hereby certify that I attended the deceased from February 3
1947, to February 10 1947;
 that I last saw him alive on February 10 1947
 and that death occurred on the date and hour stated above.

4. Sex Male O 5. Color or race white
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Olivia Wenner (deceased)
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 7 1872
 (Month) (Day) (Year)

Immediate cause of death Lymphosarcoma
 Duration 6 mo

Due to _____
 Due to _____

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

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>11</u>	<u>3</u>	hr. _____ min. _____

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

10. Usual occupation Retired

MOTHER FATHER

11. Industry or business _____

12. Name Peter Wenner
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)

14. Maiden name Christina Able
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

PHYSICIAN

Major findings:
 Of operations Artery lymph node biopsy July 9, 1946 - metastatic Ca
 Of autopsy Lymphosarcoma of liver, spleen, ad. retro peritoneal lymph node metastatic nodes

Underline the cause to which death should be charged statistically.

16. (a) Informant Charles F. Wenner
 (b) Address 2501 Minnesota

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12/47
 (Month) (Day) (Year)

(c) Place: burial or cremation Catholic

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? _____

18. (a) Signature of funeral director Thaddeus J. ...
 (b) Address 2406 ...

19. (a) FEB 11 1948 (Date received local registrar) J. F. Bredenk (Registrar's signature)

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

23. Signature Waver F. ... (M. D. or other) O
 Address Barnard Free Skin and Ca. Hosp Date signed Feb 10 47

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.....

Les J Buddle

Licensed Embalmer No.....

3489

P. O. Address.....

St Louis MO

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.