

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

25761

State File No.

No. 300
10-48

FILED JUL 16 1949

BIRTH NO. _____		REG. DIST. NO. <u>319</u>		PRIMARY REG. DIST. NO. <u>6079</u>		Registrar's No. <u>42</u>	
1. PLACE OF DEATH a. COUNTY <u>STE GENEVIEVE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>STE GENEVIEVE</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL STEGENEVIEVE TS LIFE</u>		c. LENGTH OF STAY (in this place) <u>1</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL STE GENEVIEVE</u>		75	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NONE</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>THERESA</u>			b. (Middle) _____			c. (Last) <u>KARL</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 12 1949</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>OCT 10 1867</u>	
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>NEW OFFENBURG MO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13a. FATHER'S NAME <u>JOSEPH GELL</u>			13b. MOTHER'S MAIDEN NAME <u>VICTORIA BRISCHKE</u>		14. NAME OF HUSBAND OR WIFE <u>HENRY KARL</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Nancy Karl Wiegarten</u> ADDRESS _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Atherosclerosis</u>					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pulmonary Disease</u> DUE TO (c) <u>Osteo Arthritis</u>					3 days
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Valvular heart disease</u> <u>Chronic Myocarditis</u>					several days
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4500</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>June 6, 1949</u> to <u>July 12, 1949</u> , that I last saw the deceased alive on <u>July 11, 1949</u> , and that death occurred at <u>8:15</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. W. W. Wiegarten</u>				23b. ADDRESS <u>St. Genevieve Mo</u>		23c. DATE SIGNED <u>July 12 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JULY 14 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>WEINLARTEN</u>		24d. LOCATION (City, town, or county) (State) <u>WEINLARTEN MO</u>	
DATE REC'D BY LOCAL REG. <u>July 15-49</u>		REGISTRAR'S SIGNATURE <u>L. D. Karl</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Geo. C. Baker</u>		ADDRESS <u>St. Genevieve Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 7-16-49

Health Officer No. 4

District File Number 749-934

Date Filed

Robert J. ...

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

X Student Embalmer No. *37/101A*

working under my personal supervision.

Student *Adrian Miller*
Student Embalmer

Signed *Leslie Barker*

Licensed Embalmer No. *1985*

P. O. Address *St. ...*

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.