

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11745

State File No. ....

**BIRTH NO.** \_\_\_\_\_ **REG. DIST. NO.** 364 **PRIMARY REG. DIST. NO.** 6237 **Registrar's No.** 2

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).		
a. COUNTY <b>Warren</b>			a. STATE <b>Mo</b>		b. COUNTY <b>St. Charles</b>
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Hickory Grove</b>		c. LENGTH OF STAY (in this place) <b>4 Years</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Hickory Grove</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location) <b>Near Foristell</b>		
<b>3. NAME OF DECEASED</b> (Type or Print)			<b>4. DATE OF DEATH</b> (Month) (Day) (Year)		
a. (First) <b>Alvina</b>		b. (Middle)	c. (Last) <b>Joerling</b>		<b>March, 6, 1950</b>
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>April, 26, 1880</b>	<b>9. AGE</b> (In years last birthday) <b>69</b>	<b>10. IF UNDER 1 YEAR</b> Months _____ Days _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>mo</b>
<b>13a. FATHER'S NAME</b> <b>John T wiehous</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Enetie Schuttenberg</b>		<b>14. NAME OF HUSBAND OR WIFE</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>0</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Mrs Clarence Welge Foristell, Mo</b>	
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Meta static Carcinomatosis</b>  <b>ANTECEDENT CAUSES</b> <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (b) <b>Primary Carcinoma of Colon</b>  DUE TO (c) _____  <b>II. OTHER SIGNIFICANT CONDITIONS</b> <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 year</b> <b>2 years</b>  <b>153X</b>
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>			<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>May</u> 19<u>49</u> to <u>March</u> 19<u>50</u>, that I last saw the deceased alive on <u>2/25</u>, 19<u>50</u>, and that death occurred at <u>3:35 p.m.</u>, from the causes and on the date stated above.</b>					
<b>23a. SIGNATURE</b> (Degree or title) <b>H.C. McMurray, M.D.</b>			<b>23b. ADDRESS</b> <b>Wentzville, Mo.</b>		<b>23c. DATE SIGNED</b> <b>3/7/50</b>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24b. DATE</b> <b>3-9-50</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Ferns Orage</b>	
<b>24d. LOCATION</b> (City, town, or county) (State) <b>Ferns Orage, Mo</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Mrs. F. W. Hughes</b>			
<b>DATE REC'D BY LOCAL REG.</b> <b>Mar. 8, 1950</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mrs. F. W. Hughes</b>		<b>ADDRESS</b> <b>335 Main Street, Wentzville, Mo</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 2 1950

RECEIVED MAR 13 1950  
District Health Officer No. 9  
District File Number

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.....

Student Embalmer No. ....

working under my personal supervision.

Signed *Morris Marchant*

Signed.....  
Student Embalmer

Licensed Embalmer No. *2461*

P. O. Address *Wentzville 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.