

FILED DEC 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42067

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10356**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION INCARNATE WORD.		d. STREET ADDRESS (If rural, give location) 1728 CALIFORNIA AV. 23	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) IDA	b. (Middle) L.	c. (Last) BUEHRLE	(Month) DEC	(Day) 4	(Year) 50

5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH DEC-28-1879	9. AGE (In years last birthday) 70 YRS	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
-----------------	---------------------------	---	-------------------------------------	---	------------------------	----------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY own	11. BIRTHPLACE (State or foreign country) ST CHARLES, CTY MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
--	--	--	--	--	--

13a. FATHER'S NAME CHARLES WEHMEYER	13b. MOTHER'S MAIDEN NAME MARIA UNKNOWN	14. NAME OF HUSBAND OR WIFE ADOLPH BUEHRLE	
--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Adolph Buehrle		ADDRESS 1728 California	
--	-------------------------	---	--	--------------------------------	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy			INTERVAL BETWEEN ONSET AND DEATH 70-26-	
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis			3 yr	
	DUE TO (c) Diabetes mellitus			6 yr	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
------------------------	----------------------------------	--	---	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 260X
---	--	--

22. I hereby certify that I attended the deceased from **Nov 20**, 19**50**, to **Dec 4**, 19**50**, that I last saw the deceased alive on **Dec 4**, 19**50**, and that death occurred at **4:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)	23b. ADDRESS 506 Olive St.	23c. DATE SIGNED 12/5/50
---	-----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE DEC-7-50	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
---	---------------------------	---	--

DATE REC'D BY LOCAL REG. DEC 5 1950	REGISTRAR'S SIGNATURE J.P. Kessler	25. FUNERAL DIRECTOR'S SIGNATURE E.J. Schmeier	ADDRESS 3125 Lafayette Ave
--	---	---	-----------------------------------

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Joseph B. Vollmer

Signed
Student Embalmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette Ave*

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.