

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11679**

S. No. 300
V. 10.48

FILED APR 23 1951

BIRTH NO. _____		REG. DIST. NO. 42	PRIMARY REG. DIST. NO. 1000	Registrar's No. 421
1. PLACE OF DEATH a. COUNTY BUCHANAN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY BUCHANAN		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST-JOSEPH-		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST-JOSEPH. 0117		
d. FULL NAME OF HOSPITAL OR INSTITUTION 1811 WASHINGTON AV.		d. STREET ADDRESS (If rural, give location) 1811 WASHINGTON - AV.		
3. NAME OF DECEASED (Type or Print) a. (First) PAULINE		b. (Middle) -		c. (Last) WEDDEL
4. DATE OF DEATH (Month) (Day) (Year) APR-16-1951				
5. SEX FEMALE	6. COLOR OR RACE WHT	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JUNE-9-1865	9. AGE (In years last birthday) 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT-HOME		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) GERMANY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Do-NOT-KNOW		13b. MOTHER'S MAIDEN NAME Do-NOT-KNOW		14. NAME OF HUSBAND OR WIFE EDWARD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Mrs. Amelia Comella ADDRESS St. Joseph, Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 days
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General Arterio-Sclerosis		3 yrs.
		DUE TO (c) Senility		1 year
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.)		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?
22. I hereby certify that I attended the deceased from 04/17, 1951 , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:30 a.m. , from the causes and on the date stated above.				
23a. SIGNATURE H. F. Mundy, M.D. (Degree or title) 3		23b. ADDRESS St. Joseph, Mo.		23c. DATE SIGNED 4/17/51
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 4-18-51		24c. NAME OF CEMETERY OR CREMATORY ASHLAND Cem.
24d. LOCATION (City, town, or county) (State) ST-JOSEPH- MO		25. FUNERAL DIRECTOR'S SIGNATURE Stamer Funeral Home - St. Joseph ADDRESS		
DATE REC'D BY LOCAL REG. April 20, 1951		REGISTRAR'S SIGNATURE Carl C. Casler		

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John W. Stacey

Licensed Embalmer No. 24357

P. O. Address H. Joseph

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.