

FILED NOV 1 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34337

BIRTH NO. _____		REG. DIST. NO. 207		PRIMARY REG. DIST. NO. 1318		Registrar's No. 48	
1. PLACE OF DEATH a. COUNTY Maries				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Maries			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Vienna, Mo.				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Vienna, Mo.			
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) John Herman Wessels				4. DATE OF DEATH (Month) (Day) (Year) Oct. 24, 1951.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 10, 1888	
9. AGE (In years last birthday) 62		10. MONTH (Day) (Year) 10 14		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Herman Wessels		13b. MOTHER'S MAIDEN NAME Anna Asmus		14. NAME OF HUSBAND OR WIFE Onnie Wessels			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Onnie Wessels, ADDRESS Vienna, Mo.			
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) Chronic myocarditis (rheumatic) ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES ☐ NO ☒	
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 ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from July 25, 1940 , to May 7, 1951 , that I last saw the deceased alive on 10/22/51 , 19 51 , and that death occurred at 3:05A m., from the causes and on the date stated above.							
23a. SIGNATURE (Typed or title) J. C. Howard				23b. ADDRESS Vienna, Missouri		23c. DATE SIGNED 10/26/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct. 27, 1951		24c. NAME OF CEMETERY OR CREMATORY Visitation Cemetery		24d. LOCATION (City, town, or county) (State) Vienna, Mo.	
DATE REC'D BY LOCAL REG. 10-26-51		REGISTRAR'S SIGNATURE Pauline Howard		25. FUNERAL DIRECTOR'S SIGNATURE M. C. Cunningham		ADDRESS Vienna, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

File No. _____
DISTRICT HEALTH OFFICE No. 4

OCT 30 1951
RECEIVED

VS APR 6 1960

DEC 9 1951

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.