

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36064

State File No.

923
10 OCT 27 1952

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 220

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Peters, rural	
c. LENGTH OF STAY (In this place) 5 wks		d. STREET ADDRESS (If rural, give location) 2 miles south St. Peters	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Fredrick	b. (Middle) P.	c. (Last) Wehmeier	4. DATE OF DEATH (Month) (Day) (Year)
				10-21-52

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 3-1-1888	9. AGE (In years) (Months) (Days) 64 7 11	IF UNDER 1 YEAR IF UNDER 1 HOUR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) St. Louis Co. Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Herman Wehmeier	13b. MOTHER'S MAIDEN NAME Katherine Rienback	14. NAME OF HUSBAND OR WIFE Louise Wehmeier
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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 Clarence Wehmeier	ADDRESS 1149 Hall St. St. Charles, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia	DUPLICATE OF (a) Pneumonia		
ANTECEDENT CAUSES	DUPLICATE OF (b) Cardiac Decompensation		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUPLICATE OF (c) Ch. Myocarditis		
II. OTHER SIGNIFICANT CONDITIONS	generalized arteriosclerosis		
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4221	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (Min.)	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 Jan 1, 1957, to Oct 21, 1952, that I last saw the deceased alive on 10-21, 1952, and that death occurred at 5:40 A.M., from the causes and on the date stated above.

23a. SIGNATURE George R. Sosolik M.D. (Degree or title)	23b. ADDRESS Dallan Mo.	23c. DATE SIGNED 10-22-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-23-52	24c. NAME OF CEMETERY OR CREMATORY St. John's	24d. LOCATION (City, town, or county) (State) Cottleville, Mo.
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DATE REC'D BY LOCAL REG. 10-22-52	REGISTRAR'S SIGNATURE Francis Hamilton	25. FUNERAL DIRECTOR'S SIGNATURE Geo. Steffater	ADDRESS St. Peters, Mo.
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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 E. K. Keithly

Licensed Embalmer No. 822

P. O. Address Fallon 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.