

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 1 1955

State File No. 28293

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u>)		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4243 Wyoming St.</u>				STREET ADDRESS (If rural, give location) <u>16 4243 Wyoming St.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>OTTO</u>		b. (Middle) _____		c. (Last) <u>WIESE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 2 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 7, 1881</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Mechanic-Public Service Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____			
11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Unknown Wiese</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Mary Wiese</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mary Wiese</u> ADDRESS <u>4243 Wyoming St.</u>					
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) <u>Cerebral Haemorrhage</u> ANTECEDENT CAUSES Morbid 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 <u>18 hours</u>	
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) _____		21f. HOW DID INJURY OCCUR? _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>July 7th, 1955</u> , to <u>Aug 2nd, 1955</u> , that I last saw the deceased alive on <u>Aug 2nd, 1955</u> , and that death occurred at <u>7:10 P.M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>Paul B. Webb</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>1915^a Sidney St.</u>		23c. DATE SIGNED <u>8/4/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Aug. 6, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>			
DATE REC'D BY LOCAL REG. <u>AUG 4 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Kriegshauser 4228 S. Kingshighway Bl.</u>					

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.....
Signature of Student Embalmer

Signed *Richard W. Storrs*.....

Licensed Embalmer No...*4*.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.