

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31654**  
**8376**  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <b>St. Louis</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>234</b>	
e. STREET ADDRESS (If rural, give location) <b>23 2648 a Lafayette Ave.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Edward</b> b. (Middle) <b>W.</b> c. (Last) <b>Wetteroff</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 23, 1955</b>
--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 7, 1903</b>	9. AGE (In years last birthday) <b>52</b>	# UNDER 1 YEAR <b>6</b>	MONTHS <b>6</b>	YEARS <b>16</b>	# UNDER 2 HRS. <b></b>	MIN. <b></b>
--------------------	-------------------------------	---	--------------------------------------	---	-------------------------	-----------------	-----------------	------------------------	--------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hardware Store</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	--	--	--

13a. FATHER'S NAME <b>Charles Wetteroff</b>	13b. MOTHER'S MAIDEN NAME <b>Ida Bollinger</b>	14. NAME OF HUSBAND OR WIFE <b>Florence Wetteroff</b>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Florence Wetteroff</b>	ADDRESS <b>2648a Lafayette</b>
--	-------------------------------	---	--------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerosis heart disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) starting 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. <b>Cardiac asthma</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>420.0</b>	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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	---	----------------------------

22. I hereby certify that I attended the deceased from Aug 1, 1955, to Sept 23, 1955, that I last saw the deceased alive on 9/23/55, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE <b>Ralph Berg</b> (Degree or title)	23b. ADDRESS <b>3203 S Grand</b>	23c. DATE SIGNED <b>9/23/55</b>
--	----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Sept. 26, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>
--	---------------------------------	---	---

DATE REC'D BY LOCAL REG. <b>SEP 23 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Schumacher</b>	ADDRESS <b>3013 Meramec St.</b>
---	---	--	---------------------------------

**S.P.** (Licensed Embalmer's Statement on Reverse Side)

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

DR. RALPH BERG  
3202 So. GRAND.

Pr. 3-7857

11:30 A.M. LUTHERAN HOSPITAL

---

**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 *V E Morris*.....

Licensed Embalmer No. *336*

P. O. Address *St Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.