0.300
0.48

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

FILED APR 6 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11603

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3054

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St Louis
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Deaconess Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Raymond
d. STREET ADDRESS (If rural, give location): 812 0 8

3. NAME OF DECEASED (Type or Print)
a. (First): Harry
b. (Middle): L
c. (Last): Wernsing

4. DATE OF DEATH (Month) Mar (Day) 24 (Year) 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug 10,1896

9. AGE (In years last birthday): 59 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and State or Foreign Country): Harvel Illinois

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Herman Wernsing

13b. MOTHER'S MAIDEN NAME: Tena Berhusen

14. NAME OF HUSBAND OR WIFE: Laura Wernsing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S SIGNATURE OR NAME: Laura Wernsing
ADDRESS: Raymond Ill

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic Coma — 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) Acute yellow atrophy of the liver — 2 weeks
DUE TO (c)

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: 580x
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) m.
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* April 7 *19*53, *to* March 24, *19*56, *that I last saw the deceased alive on* March 24 *19*56, *and that death occurred at* 11:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE: J. J. Nash (Degree or title): M.D.
23b. ADDRESS: 634 N. Grand Blvd.
23c. DATE SIGNED: 3-26-56

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 3-25-56
24c. NAME OF CEMETERY OR CREMATORY: City
24d. LOCATION (City, town, or county) (State): Harvel Illinois

DATE REC'D BY LOCAL REG.: MAR 26 1956
REGISTRAR'S SIGNATURE: J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert H. Hoppe 4700 Washington
m & B.
(Licensed Embalmer's Statement on Reverse Side)

JAN 14 1963

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 [illegible]

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.