

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41098

STATE FILE NUMBER

FILED JAN 10 1957

Registration District No. 119 Primary Registration District No. 5443 Registrar's No. 55

1. PLACE OF DEATH a. COUNTY <u>GASCONADE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>GASCONADE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ROARK</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>HERMANN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>TRAVEL VALLEY REST HOME</u> Length of stay in 1b <u>10 DAYS</u>		d. STREET ADDRESS <u>W. 14th ST</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>GEORGE WERLE</u> First Middle Last			4. DATE OF DEATH <u>DEC-16-1956</u> Month Day Year		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-1-1866</u>	9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>GASCONADE Co.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13. FATHER'S NAME <u>GEORGE WERLE</u>	14. MOTHER'S MAIDEN NAME <u>KATY PHILLIP</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Edwin ALLEMAN</u> Address <u>HERMANN Mo</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ARTERIOSCLEROSIS</u>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year <u>a. m. p. m.</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 11-26-56 to 12-16-56 and last saw ^{her} _{him} alive on 12-16-56
Death occurred at 7:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Carroll F. Shaw, M.D.</u>	22b. ADDRESS <u>Hermann, Mo.</u>	22c. DATE SIGNED <u>12-18-56</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-19-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>STONY HILL Mo</u>
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24. FUNERAL DIRECTOR <u>HAROLD BLUMER</u> ADDRESS <u>Hermann Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12/15/56</u>	26. REGISTRAR'S SIGNATURE <u>Edwin Gerken</u>
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(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300 1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

MEDICAL CERTIFICATION

19-3

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 *Chas. H. Pope*.....

Licensed Embalmer No. *255*

P. O. Address *Herman*.....

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.