

XC-20 166 893

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10947

SL 12573 FILED MAR 18 1957

318

1003

STATE FILE NUMBER

2035

Registration District No. Primary Registration District No. Registrar's No.

Health, Welfare, Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>915 N. Grand, St. Louis, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>New Baden</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET. ADM. HOSPITAL</u> Length of stay in 1b <u>043 days</u>		d. STREET ADDRESS <u>Route #1</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERNARD</u> Middle Last <u>RENSING</u>			4. DATE OF DEATH <u>FEBRUARY 27, 1957</u> Month Day Year
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>2/3/93</u>
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Damiansville, Ill. /</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>August Rensing</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Buetmann</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW-1</u>	
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>VA HOSP. RECORDS, ST. LOUIS, MO.</u> Address	
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>ACUTE BRONCHOPNEUMONIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>UNK.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>- - -</u> DUE TO (c) <u>- - -</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>BILIARY CIRRHOSIS</u>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>- - -</u>	
20c. TIME OF INJURY <u>Hour Month, Day, Year</u> a. m. p. m.		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 <u>NEW BADEN, ILL.</u> COUNTY STATE	
21. Attended the deceased from <u>1/15/57</u> to <u>2/27/57</u> and last saw <u>him</u> alive on <u>2/27/57</u> Death occurred at <u>1:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Regd. or title) <u>Wesphaelinger</u>		22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>	22c. DATE SIGNED <u>2/27/57</u>
23a. LOCAL CREMATION REMOVAL (If any)	23b. DATE <u>2-27-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WESTYPHAELINGER</u>	23d. LOCATION (City, town, or county) (State) <u>New Baden, Ill.</u>
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, 4700 Washington Blvd.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>FEB 28 '57</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. W. Wilkinan*
.....

Licensed Embalmer No. *35*

P. O. Address *M. Lane*

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