

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15578**

FILED APR 29 1957

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **910**

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CLAYTON		c. CITY OR TOWN ST. JOHN	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSP.		e. STREET ADDRESS (If rural, give location) 2932 RIDGEWAY AVE.	

3. NAME OF DECEASED (Type or Print) JOSEPH	a. (First)	b. (Middle)	c. (Last) WENZARA	4. DATE OF DEATH (Month) (Day) (Year) 4 3 1957
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH AUG. 24, 1904	9. AGE (In years last birthday) 52	If UNDER 1 YEAR Months Days	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) DESIGNER	10b. KIND OF BUSINESS OR INDUSTRY UNIVERSAL MATCH	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MO.	12. CITIZEN OF WHAT COUNTRY? U-S-A.
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13a. FATHER'S NAME JOSEPH WENZARA	13b. MOTHER'S MAIDEN NAME VIOLET WALTHERS	14. NAME OF HUSBAND OR WIFE ADELE M. WENZARA
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME ADELE M. WENZARA	ADDRESS 2932 RIDGEWAY AVE
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease		
	DUE TO (c) Diabetes Mellitus		
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	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4-1, 1957**, to **4-3, 1957**, that I last saw the deceased alive on **4-3, 1957**, and that death occurred at **12:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph G. Cuneo MD	23b. ADDRESS 601 S. BRENTWOOD BLVD.	23c. DATE SIGNED 4-3-57
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24a. BURIAL, CREMATION, OR REMOVAL (Specify)	24b. DATE 4-6-1957	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.	24d. LOCATION (City, town, or county) (State) LEMAV, MO.
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DATE REC'D BY LOCAL REG. 4-5-57	REGISTRAR'S SIGNATURE Herbert B. Donahoe	25. FUNERAL DIRECTOR'S SIGNATURE Waldmann Bros. Inc.	ADDRESS 504 WOODSON RD - OVERLAND, MO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

S. No. 500
EV. 10 48

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 *David C. Gibson*.....

Licensed Embalmer No. *3454*.....

P. O. Address *Portland, Or*.....

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