

Health
Welfare
Public
Service

300
-56

Doctor, when 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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26678

STATE FILE NUMBER

6737

FILED JUL 31 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6737**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mo	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ALEXIAN BRAS HOSPITAL 24		d. STREET ADDRESS 3122 NEBRASKA (If outside, give location)	
3. NAME OF DECEASED (Type or print) BERNARD - WEGENER		4. DATE OF DEATH JULY 17 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 2 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BRICK CONTRACTOR		11. BIRTHPLACE (City and state or country) GERMANY	
13. FATHER'S NAME UNKNOWN WEGENER		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 492-22-1975	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE FAILURE DUE TO (b) ARTERIO SCLEROTIC HEART DUE TO (c) disease with UREMIA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH few yrs 1 mo	
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.) 420.0	
20c. TIME OF INJURY Hour Month, Day, Year 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 COUNTY STATE	
21. I attended the deceased from May 1957 to 7-17-57 and last saw him live on 7-17-57 . Death occurred at 11:00 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. Michael M.D.		22b. ADDRESS 812 Olive	
22c. DATE SIGNED 7/19/57		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 20 1957	
23c. NAME OF CEMETERY OR CREMATORY S. S. PETER & PAUL		23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo	
24. FUNERAL DIRECTOR ADDRESS Thomas Kates 2906 Georgia		25. DATE RECD. BY LOCAL REG. JUL 19 1957	
26. REGISTRAR'S SIGNATURE Carl Smith M.D.		27. (Licensed Embalmer's Statement on Reverse Side) MRS	

11-3 P.M.
Dec 1-1904

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]
Signature of Student Embalmer

Signed [Signature]

Licensed Embalmer No. 430

P. O. Address 2906

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.