

FILED DEC 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46453

STATE FILE NUMBER 12020

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

S. 300
1-57

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital		Length of stay in 1b 1 week 2 23		d. STREET ADDRESS (If outside, give location) 2653 Ohio Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Euphemia Middle M. Last Wempe				4. DATE OF DEATH Month Dec. Day 13 Year 1957			
5. SEX Female	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 Aug. 24, 1865		9. AGE (In years last birthday) 92 Months 4 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Avoston, Illinois.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME William Dulle			13b. MOTHER'S MAIDEN NAME Anna Hundmann			14. NAME OF HUSBAND OR WIFE Bernard Wempe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Rt. Rev. A. A. Wempe 2653 Ohio Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis Dec 11 - 6 hrs essential Arteriosclerosis Senility Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 422.1						19. WAS AUTOPSY PERFORMED? 2 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 _____ 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 DEC 9 17 to DEC 12 17 and last saw her alive on 12/13/57 Death occurred at 1:30 A.M. Laetitia to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Name or title) John H. Gebken				22b. ADDRESS 506 Olive St.		22c. DATE SIGNED 12-13-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12/16/57		23c. NAME OF CEMETERY OR CREMATORY St. Peter		23d. LOCATION (City, town, or county) (State) St. Charles, Mo.	
24. FUNERAL DIRECTOR John H. Gebken Soms				ADDRESS 2630 Gravois Ave.		25. DATE RECD. BY LOCAL REG. DEC 14 57	
				26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

St. Louis, Mo. x
 St. Anthony Hospital
 523 Olive Ave.
 Dec. 13 1927
 Philadelphia
 x
 1865 St. Ave.
 U.S.A.
 Westmoreland
 Pennsylvania
 U.S.A.
 None

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 Signed *Robert J. Glick*
 Signature of Student Embalmer

Licensed Embalmer No. 4144
 P. O. Address 2630 Gravois Ave.

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.