Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-003800
STATE FILE NUMBER

FEB 11 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 148

1. PLACE OF DEATH
a. COUNTY St. Louis

b. CITY OR TOWN Kirkwoo d — Inside Limits Yes [X] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Peace Haven Home — Length of stay in 1b MONS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis

c. CITY OR TOWN Kirkwood 4673 — Inside Limits Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location) 222 Barter — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Erna Middle: E Last: Gutman

4. DATE OF DEATH Month Day Year: January 15, 1959

5. SEX: female 1

6. COLOR OR RACE: white

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]

8. DATE OF BIRTH: Nov. 22, 1878

9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (City and state or country): Belleville Illinois 1

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Herman Wehring

13b. MOTHER'S MAIDEN NAME: ~~Ernestine~~ Klein

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT: Mrs. Thelma L. Burke Address Forth Worth Tex.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Unknown Natural Causes
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

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7954

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John C. Murphy M.D. (Degree or title) 5
John C. Murphy MD Acting Health Commissioner

22b. ADDRESS 801 S. Brentwood Clayton, Mo.

22c. DATE SIGNED 1/22/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 1/17/59

23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery

23d. LOCATION (City, town, or county) St. Louis County (State) Missouri.

24. FUNERAL DIRECTOR C.R. Lupton and Sons ADDRESS 7233 Delmar Blv'd.

25. DATE RECD. BY LOCAL REG. 1-15-59

26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

## 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 Clarence H. Murray

Licensed Embalmer No. 7611

P. O. Address St. Louis, Mo.

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.