

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004056
STATE FILE NUMBER

FILED JAN 26 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 154

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-57

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, give TOWNSHIP only) St. Ferdinand Twp		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN St. Ferdinand Twp 4000 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Villa Gesu INSTITUTION		Length of stay in lb YRS.	d. STREET ADDRESS (If outside, give location) 11755 Riverview Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Sister Mary Adelgundis Wenzel			4. DATE OF DEATH Month January Day 15th , Year 1959		
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5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1880	9. AGE (In years at birthday) 78	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY religious	11. BIRTHPLACE (City and state or country) Stockheim Germany 4	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Herman Wenzel	13b. MOTHER'S MAIDEN NAME Katherine Bernhardt	14. NAME OF HUSBAND OR WIFE none
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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 Sister M. Nicoletta, 11755 Riverview
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction with disease		INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cardiac decompensation	
	DUE TO (c) Senility	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from 1956 to 1-15-1959 and last saw her alive on 1-13-59 Death occurred at 2:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE John C. Murphy (Degree or title) MD	22b. ADDRESS 832 1/2 N Broadway	22c. DATE SIGNED 1-15-59

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 1/17/59	23c. NAME OF CEMETERY OR CREMATORY Villa Gesu	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR DDIEDRICH FUNERAL HOME, 8319 Hallsferry	ADDRESS	25. DATE RECD. BY LOCAL REG. 1-16-59	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Name of Deceased
 Date of Death
 Place of Death
 Name of Embalmer
 License No. of Embalmer
 City and State of Embalmer
 Name of Student Embalmer
 License No. of Student Embalmer
 City and State of Student Embalmer
 Name of Physician
 License No. of Physician
 City and State of Physician
 Name of Undertaker
 License No. of Undertaker
 City and State of Undertaker

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 *Lawrence O. Decker*
 Licensed Embalmer No. *4979*
 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.