

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011539  
STATE FILE NUMBER  
2 2426

FILED MAR 25 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Con. Home</b>		d. STREET ADDRESS (If outside, give location) <b>5812 Itaska St.</b>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>MAGDALEN WOELBLING</b>			4. DATE OF DEATH Month Day Year <b>Mar. 8 1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sep. 24, 1880</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Joseph Lesyna</b>	13b. MOTHER'S MAIDEN NAME <b>Barbara Schmatt</b>	14. NAME OF HUSBAND OR WIFE <b>Late Gustav A. Woelbling</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and date of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Dr. W. G. Woelbling</b>	Address <b>4400 Chippewa</b>
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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) <b>Arteriosclerotic heart</b>		INTERVAL BETWEEN ONSET AND DEATH <b>week</b>
DUE TO (b) <b>Chronic Arteriosclerosis</b>		
DUE TO (c) <b>420.0</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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 <b>March 1</b> to <b>March 8</b> and last saw her alive on <b>Mar. 7/59</b> Death occurred at <b>12:05 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>Washington M.D.</b> (Degree or title)	22b. ADDRESS <b>4724 Leavies</b>	22c. DATE SIGNED <b>3/9/59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Mar. 11, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
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24. FUNERAL DIRECTOR <b>Kriegshauser</b>	ADDRESS <b>4228 S. Kings Highway</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 9 '59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
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300  
1-57  
16  
491  
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *William B White* .....

Licensed Embalmer No. *4281* .....  
P. O. Address *4221 N. Kingsley* .....

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.