

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027332

FILED VS AUG 11 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **7150**

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DEACONESS HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5527 Pershing Avenue, 12</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>WILLIAM H. WEHMEYER</b>	First Middle Last	4. DATE OF DEATH <b>August 1st, 1959</b>	Month Day Year
---	-------------------	---	----------------

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-69</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	------------------------------------	-------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Guard</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>City of St. Louis</b>	11. BIRTHPLACE (City and state or country) <b>Fenton, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	---	---	---

13a. FATHER'S NAME <b>Frederick Wehmeier</b>	13b. MOTHER'S MAIDEN NAME <b>Doria (Unknown)</b>	14. NAME OF HUSBAND OR WIFE <b>Catherine Wehmeier</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>498-18-5301</b>	17. INFORMANT <b>Mrs. Alfred Laumann, 1625 June Dr. 37</b>	Address
---	---	---	---------

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>Coronary Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) <b>177x</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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.)
---	---	--

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 <b>6-16-59</b> to <b>7-31-59</b> and last saw her/him alive on <b>7-31-59</b> Death occurred at <b>Deacons Hospital</b> on the date stated above, and to the best of my knowledge, from the causes stated. <b>8:15 A.M.</b>
--

22a. SIGNATURE (Degree or title) <b>Edward M. Cannon M.D.</b>	22b. ADDRESS <b>607 N. Grand</b>	22c. DATE SIGNED <b>8-1-59</b>
--	-------------------------------------	-----------------------------------

23a. BURIAL-CREATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-3-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Bethlehem Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
---	----------------------------	---	--

24. FUNERAL DIRECTOR <b>CALVIN F. FEUTZ, 4828 NAT'L BRIDGE BLVD.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>AUG 3 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
---	---------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mdb*

**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 John A. Wilson

Licensed Embalmer No. 4186

P. O. Address St. Louis 7

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.