

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027353

FILED VS AUG 5 1959

3 6930

STATE FILE NUMBER

INDEXED

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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4 days	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 DePaul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5922 Goodfellow Blvd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First CHARLES Middle S. Last WIEMAN	4. DATE OF DEATH Month July Day 24 Year 1959
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5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/31/1898	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman	10b. KIND OF BUSINESS OR INDUSTRY shoe	11. BIRTHPLACE (City and state or country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Henry Wieman	13b. MOTHER'S MAIDEN NAME Anna Hinden	14. NAME OF HUSBAND OR WIFE Viola Wieman
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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. 492-01-5920	17. INFORMANT Viola Wieman Address 5922 Goodfellow Blvd
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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) acute heart failure DUE TO (b) arteriosclerotic cardiovascular disease years DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) acute cerebrovascular accident		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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 St. Louis	COUNTY Mo.	STATE
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21. I attended the deceased from **11/1/56** to **7/24/59** and last saw her/him alive on **7/24/59**
Death occurred at **8:20 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert A Bauer MD (Degree or title)	22b. ADDRESS 3731 Goodfellow	22c. DATE SIGNED 7/25/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 7/27/59	23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery	23d. LOCATION (City, town, or county) St. Louis County	(State) Mo.
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24. FUNERAL DIRECTOR Buchholz Mortuary ADDRESS 5967 W. Florissant	25. DATE RECD. BY LOCAL REG. JUL 27 '59	26. REGISTRAR'S SIGNATURE Carl Smith. M.D.
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m. g. b.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. Alfred M. Busch

Licensed Embalmer No. 7557

P. O. Address St. Louis

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.