

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030895

FILED VS SEP 4 1959

2 7858

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 <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND ST LOUIS MO</b>		Length of stay in 1b <b>280 DAYS</b>	c. CITY OR TOWN <b>ST LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETS ADMIN HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6126 WATERMAN</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>C.</b> Last <b>WIESEMANN</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>20</b> Year <b>1959</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/95</b>
10a. USUAL OCCUPATION (Give kind of work done of working life, even if retired) <b>WATCHMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>64</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>ST LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>WILLIAM C WIESEMANN</b>		13b. MOTHER'S MAIDEN NAME <b>HANNAH RESS</b>	14. NAME OF HUSBAND OR WIFE -----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>331-09-9426</b>	17. INFORMANT <b>VA HOSP RECORDS 915 N GRAND ST LOUIS MO</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>MYOCARDIAL INFARCTION WITH SHOCK&amp;PULMONARY EDEMA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>LESS 24 HRS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CORONARY THROMBOSIS</b>			<b>LESS 24 HRS</b>
DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			<b>15 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>GENERAL PARESIS</b>			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 checked="" type="checkbox"/> NO <input 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 a.m. p.m. <b>VA 11/13/58</b>	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 <b>8/20/59</b>
21. attended the deceased from <b>8:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Henry A Fozard</b> (Degree or title) <b>N.D.</b>		22b. ADDRESS <b>VAH, ST LOUIS, MISSOURI</b>	22c. DATE SIGNED <b>8/21/59</b>
23a. BURIAL, CREMATION, REMOVAL, SPREAD, ETC. <b>Removal</b>		23b. DATE OF BURIAL, CREMATION, REMOVAL, SPREAD, ETC. <b>8/25/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>
24. FUNERAL DIRECTOR <b>Edw. Fendler Mortuary 5611 So. Grand Blvd.</b>		23d. LOCATION (City, town, or county) <b>Jefferson Bks., MO.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 24 '59</b>
26. REGISTRAR'S SIGNATURE <b>Keal Smith, M.D.</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 T. D. Humphrey

Licensed Embalmer No. 4772

P. O. Address Sullivan

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.