

FEDERAL BUREAU OF INVESTIGATION  
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033158

FILED Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2429 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKWOOD</u>		Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>Caseyville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST JOSEPH'S Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>25 Weinel Court</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRIETTA MARGARET WECKER</u>			4. DATE OF DEATH Month Day Year <u>8 14 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-29</u>	9. AGE (last birthday) <u>30</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Aviston, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>Henry Hilmes</u>	13b. MOTHER'S MAIDEN NAME <u>Sylvester M. Wecker</u>	14. NAME OF HUSBAND OR WIFE <u>Sylvester M. Wecker</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>319-28-2663</u>	17. INFORMANT <u>Sylvester M. Wecker, Caseyville, Ill</u>
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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) <u>Cardiac arrest due to close proximity to tree struck by lightning</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
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 checked="" type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Struck by bolt of lightning while on camping trip</u>
20c. TIME OF INJURY Hour <u>8:30</u> Month, Day, Year <u>8/14/60</u> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Detjen's Grove</u>
20f. CITY, TOWN, OR LOCATION <u>Cedar Hill</u>		COUNTY <u>Jefferson</u> STATE <u>Missouri</u>

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Raymond L. Hare</u> Coroner	22b. ADDRESS <u>Clayton, Mo.</u>	22c. DATE SIGNED <u>8/25/60</u>
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23. BURIAL, CREMATION, OR REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>8/17/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Aviston</u>	23d. LOCATION (City, town, or county) (State) <u>Aviston, Illinois</u>
24. FUNERAL DIRECTOR <u>Herbert B. Harty</u>	ADDRESS <u>Collinsville, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>8-15-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy</u>

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 Robert C. Michaelme, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Herbert A. Kelly

Licensed Embalmer No. 6890

P. O. Address Collinsville

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