

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 7 1960

2586-60-033287 STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights | | c. CITY OR TOWN Kirkwood | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital | | d. STREET ADDRESS (If outside, give location) St. Agnes Home | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | |
|--|--|
| 3. NAME OF DECEASED (Type or print) First Wilhelmina Middle L. Last Vieh | 4. DATE OF DEATH Month August Day 29 Year 1960 |
|--|--|

| | | | | | | |
|----------------------|-------------------------------|---|----------------------------------|----------------------------------|---|--|
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1/4/1876 | 9. AGE (last birthday) 84 | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____ |
|----------------------|-------------------------------|---|----------------------------------|----------------------------------|---|--|

| | | | |
|--|--|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Music Teacher | 10b. KIND OF BUSINESS OR INDUSTRY State College | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S. |
|--|--|--|---|

| | | |
|--|--|---|
| 13a. FATHER'S NAME Michael Vieh | 13b. MOTHER'S MAIDEN NAME Christine Peter | 14. NAME OF HUSBAND OR WIFE None |
|--|--|---|

| | | | |
|---|--|--|---------------|
| 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. Unknown | 17. INFORMANT Walter F. Vieh, Old Saybrook, Conn. | 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) cerebral thrombosis | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) _____ | |
| | DUE TO (c) _____ | |

| | | |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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 _____ COUNTY _____ STATE _____ |
|--|--|---|

21. I attended the deceased from **8-16-60** to **8-30-60** and last saw her ^{him} alive on **8-29-60**
Death occurred at **25th Ave** on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|--|------------------------------------|
| 22a. SIGNATURE (Degree or title) C. J. Voelker | 22b. ADDRESS 8787 Big Bend Blvd. | 22c. DATE SIGNED 8/30/60 |
|--|--|------------------------------------|

| | | | |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 9-2-60 | 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | 23d. LOCATION (City, town, or county) (State) Cape Girardeau, Mo. |
|---|----------------------------|---|---|

| | | | |
|---|---------|---|---|
| 24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 9-1-60 | 26. REGISTRAR'S SIGNATURE John B. Murphy M.D. |
|---|---------|---|---|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 21 1960

DEC 2 1960

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Charles R. Padwell

Licensed Embalmer No. 4077

P. O. Address St. Louis

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