

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045537

FILED VS DEC 27 1960

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 435

1. PLACE OF DEATH a. COUNTY <u>COLE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>GASCONADE</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON CITY</u>		Length of stay in 1b <u>1 DAY</u>		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CRAS E. STILL HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>12 mi. S.W. of HERMANN</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>THERESE HENRIETTA WEHMuELLER</u>				4. DATE OF DEATH Month Day Year <u>DEC 21- 1960</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4/25/1887</u>	9. AGE (last birthday) <u>73</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>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>		11. BIRTHPLACE (City and state or country) <u>STOLPE Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13a. FATHER'S NAME <u>Theo. TILLY</u>			13b. MOTHER'S MAIDEN NAME <u>ERNSTINE KUSCHEL</u>			14. NAME OF HUSBAND OR WIFE <u>Wm. WEHMuELLER</u>			
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>None</u>		17. INFORMANT Address <u>WILBERT WEHMuELLER HERMANN Mo</u>				
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>Acute renal failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic glomerulonephritis</u>							3 yrs.		
DUE TO (c)									
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"/> N- <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 checked="" 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 <u>3/6/59</u> to <u>12/21/60</u> and last saw her <sup>her</sup> <sub>live</sub> on <u>12/21/60</u> Death occurred at <u>8:23 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) <u>W. J. Jeter, M.D.</u>		22b. ADDRESS <u>Hermann, Mo.</u>		22c. DATE SIGNED <u>12/23/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/24/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN CEMETERY</u>		23d. LOCATION (City, town, or county) <u>R#2 HERMANN Mo</u>					
24. FUNERAL DIRECTOR <u>HOGO H. BLUMER</u>			ADDRESS <u>HERMANN Mo</u>		25. DATE RECD. BY LOCAL REG. <u>24 December 1960</u>		26. REGISTRAR'S SIGNATURE <u>R.P. Davis, MD - Richter, Dep.</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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed \_\_\_\_\_

Licensed Embalmer No. 3160

P. O. Address Hermann

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.