

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS DEC 19 1960

-60-048397

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 55 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Ste. Genevieve</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Ste. Genevieve</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ste. Genevieve, Mo</u>		Length of stay in 1b <u>73 Yrs</u>	c. CITY OR TOWN <u>Ste. Genevieve, Mo</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>623 LaPorte</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>623 LaPorte</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LEONA</u> Middle <u>WEHNER</u> Last <u>WEHNER</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>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>9-4-1887</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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		11. BIRTHPLACE (City and state or country) <u>Ste. Genevieve, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Louis J. Naumann</u>		13b. MOTHER'S MAIDEN NAME <u>Rosa Hauck</u>		14. NAME OF HUSBAND OR WIFE <u>Edward J. Wehner</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> , or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>Edward J. Wehner</u> Address <u>Ste. Genevieve, Mo</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>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Mo-23</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO <u>A</u> <u>Arterio Sclerotic Heart Disease</u>	<u>5 Years</u>
	DUE TO <u>B</u> <u>Hypertensive Cerebral Vasculadion</u>	<u>8 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>		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 12-9-60 to 12-12-60 and last saw her alive on 12-11-60
Death occurred at 4:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>L. W. De Gennaro M.D.</u>		22b. ADDRESS <u>Ste. Genevieve, Mo</u>	22c. DATE SIGNED <u>12-13-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-14-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	23d. LOCATION (City, town, or county) (State) <u>Ste. Genevieve, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>James A. Stanton Ste. Genevieve, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 13, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Keith Barber</u>

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

0961 02 330

STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

James H. Leaton

Licensed Embalmer No. 3817

P. O. Address St. Ignace

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.