

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-013727  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1059

FILED APR 12 1962	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3627 Vista Avenue (10)</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary Brendan Wenzel</u>	
4. DATE OF DEATH Month Day Year <u>March 31, 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-1879</u>
9. AGE (last birthday) <u>82</u>	
IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>
11. BIRTHPLACE (City and state or country) <u>St. Paul, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Wenzel</u>	13b. MOTHER'S MAIDEN NAME <u>Amelia Arens</u>
14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. _____	
17. INFORMANT Address <u>B. Mary Francine, SSM., 1100 Bellevue (17)</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>Peritonitis, cause unknown</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PAROTITIS</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 _____ Month, Day, Year _____ 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.) _____	
20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
21. I attended the deceased from <u>3-3-62</u> to <u>3-31-62</u> and last saw her alive on <u>3-31-62</u> Death occurred at <u>2:50 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>Charles S. Sherwin M.D.</u>	
22b. ADDRESS <u>4660 Maryland Av.</u>	
22c. DATE SIGNED <u>4-2-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-3-1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>A. H. Bocklage 6536 Clayton Rd.</u>	
25. DATE RECD. BY LOCAL REG. <u>4-2-62</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF  
 MEDICAL CERTIFICATION  
 DOCUMENT  
 INSTEAD OF  
 DAYE AMENDED

VS 300 Rev. 4/59  
 14005  
 2 218  
 3  
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 9576X  
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 12 460  
 13  
 46  
 USE BLACK INK OR TYPEWRITER RIBBON

**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

*John A. Heines*

Licensed Embalmer No. 4108

P. O. Address St. Louis, Mo

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.