

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048696

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 207 Primary Registration District No. Registrar's No. 36

FILED DEC 24 1963

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|---------------------|--------------|--|------------|----------|-----------------------|-----------------|
| VS 300 Rev. 4/59 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT | MEDICAL CERTIFICATION | BY AFFIDAVIT OF |
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| ITEM NO. | SHOULD READ | | | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

| | | | |
|---|---|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Maries | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Maries | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jackson Twp. | | c. CITY OR TOWN Argyle, Mo. | |
| Length of stay in lb 50 yrs. | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Her Home | | d. STREET ADDRESS (If outside, give location) Argyle, Mo. | |
| Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Gertrude Last Wieberg | | 4. DATE OF DEATH Month Dec. Day 14 Year 1963 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12/8/1880 |
| 9. AGE (last birthday) 83 | | 10. IF UNDER 1 YEAR Months 0 Days 6 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housekeeping | |
| 11. BIRTHPLACE (City and state or country) Brinktown, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Ignatius Bremer | | 13b. MOTHER'S MAIDEN NAME unknown | |
| 14. NAME OF HUSBAND OR WIFE Peter Wieberg | | Address | |
| 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. none | |
| 17. INFORMANT Peter Wieberg, Argyle, Mo. | | 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) Arteriosclerotic heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis generalized DUE TO (c) years | | INTERVAL BETWEEN ONSET AND DEATH years | |
| 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 type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 10:15 a.m. A. Month, Day, Year 12/17/63 | | 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.) St. Aloysius | | 20f. CITY, TOWN, OR LOCATION Argyle, Mo. | |
| 20g. COUNTY Maries | | 20h. STATE Mo. | |
| 21. I attended the deceased from 12/15/63 to 12/17/63 and last saw her alive on 12/15/63 Death occurred at 10:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | | 22. SIGNATURE (Degree or title) Dean A. Daylar M.D. | |
| 22a. ADDRESS Jefferson City | | 22b. DATE SIGNED 12-16-63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12/17/63 | 23c. NAME OF CEMETERY OR CREMATORY St. Aloysius | |
| 23d. LOCATION (City, town, or county) Argyle, Mo. | | (State): | |
| 24. FUNERAL DIRECTOR W. C. Birmingham | | 25. DATE RECD. BY LOCAL REG. 12-18-63 | |
| 26. REGISTRAR'S SIGNATURE Mozelle L. H. H. H. | | 27. ADDRESS | |

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

W. C. Birmingham

Licensed Embalmer No.

3664

P. O. Address

Sienna 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.

Thermit Attained 12-16-63
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