

No. 9
K21492

Registration District No. 257

Primary Registration District No. 3036

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Carmilite Sisters Home 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 years
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____ 92
(c) City or town St. Charles
(If outside city or town limits write "RURAL")
(d) Street No. Carmilite Sisters Home 5
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 721 W. Clay years.

3. (a) PRINT FULL NAME Mrs Lena WETZEL

3. (b) If veteran, name war ----- 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Louis Wetzel 6. (c) Age of husband or wife if alive, --- years

7. Birth date of deceased April 23, 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 10 16 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business -----

12. Name Charles Wetzel

18. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Mary Heckner

15. Birthplace Unknown Switzerland
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Kuring

(b) Address 5220 Lansdowne

17. (a) Burial (b) Date thereof 3/11/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation O.S.S. Peter & Paul

18. (a) Signature of funeral director Wacker-Welderle

(b) Address 2331 S. Broadway

19. (a) 3-10-41 (b) Clarence H. Measler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8
year 1941 hour 11 minute 20 A. M.

21. I hereby certify that I attended the deceased from February 25, 1941 to March 8, 1941;
that I last saw her alive on March 5, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial failure ✓
Duration 5 days

Due to -----

Due to -----

Other conditions generalized arteriosclerosis 11 yrs!
(Include pregnancy within 3 months of death)

Major findings:
Of operations -----

Of autopsy -----

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) -----

(b) Date of occurrence -----

(c) Where did injury occur? (City or town) (County) (State) -----

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 679

While at work? (Specify type of place) (e) Means of injury -----

23. Signature George Skette (M. D. or other) MD

Address St Charles, Mo Date signed 3/12/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

97

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11852

Registration District No. 757

Primary Registration District No. 3026

Registrar's No. 50

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
ROWENA MOORE

1. PLACE OF DEATH

(a) County St Charles
(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) **PREVIOUS FULL NAME** Miss Lena Wetzel
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex _____	5. Color or race _____	6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____		6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____	Months _____	Days _____	If less than one day _____ hr. _____ min.
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9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____ (City, town, or county) _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (Specify type of place)
(b) Address _____ (c) Means of injury _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH Month Mar day 8
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Myo Cardial failure
myocarditis chronic Duration ?

Due to _____
Due to _____ 128

Other conditions Generalized arteria
sclerosis (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature Geo E Kester (M. D. or other)
Address St Charles MO. Date signed _____

SUPPLEMENTARY

11852

078

11852