7. S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29502

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 8101

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

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS 96
(c) City or town FERN RIDGE (If outside city or town limits, write "RURAL") NO
(d) Street No. RURAL (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME HENRY WUEST
3. (b) If veteran, name war NONE
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased FEB. 12 1879 (Month) (Day) (Year)
8. AGE: Years 66 Months 7 Days 3 If less than one day hr. min.
9. Birthplace FERN RIDGE (City, town, or county) MO. (State or foreign country)
10. Usual occupation COPYIST
11. Industry or business COUNTY CLERK
FATHER 12. Name HENRY WUEST
13. Birthplace GERMANY (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name BARBARA SCHNAPP
15. Birthplace GERMANY (City, town, or county) (State or foreign country)
16. (a) Informant FRED W. WUEST
(b) Address CREVE COEUR, MO. R#1
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation IMMANUEL LUTH. CEM.
18. (a) Signature of funeral director
(b) Address 2504 Woodson Rd. Overland, Mo.
19. (a) SEP 17 1945 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 15 year 1945 hour 4 minute O.O.P. M.
21. I hereby certify that I attended the deceased from Nov. 9 1942 to 9-15 1945 that I last saw he alive on 9-15 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis (CHR.)
Due to
Due to
Other conditions (Include pregnancy within 3 months of death) 93 d.
Major findings: Of operations
Of autopsy

Duration

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M.D. or other)
Address 4500 Olive Date signed 9/17

(Licensed Embalmer's Statement on Reverse Side)

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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address Overland 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 this body is not embalmed, fact should be so stated above.