

FILED MAR 24 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11689

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 2682

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:
Missouri Pacific Hospital
(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) PRINT FULL NAME William Samuel Wester
3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bertha Wester 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased August 5 1886
(Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days 4 If less than one day hr. _____ min.

9. Birthplace Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Telegrapher

11. Industry or business Mo. Pacific R.R.

12. Name W. E. Wester

13. Birthplace Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Mrs. Bertha Wester

(b) Address Brookland, Ark.

17. (a) Removal (b) Date thereof 3-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jonesboro, Ark.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAR 23 1947 (b) J. F. Brudeck
(Date received for record) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Craig Head
(c) City or town Brookland
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 2
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 9
year 1947 hour 12:40 minute PM. M.

21. I hereby certify that I attended the deceased from Feb 26
1947, to 9 Mar. 1947

that I last saw him alive on 9 Mar. 1947
and that death occurred on the date and hour stated above.

Immediate cause of death:
1 Coronary Occlusion
2 Hypertension C.V. D.

Due to _____

Due to _____

Other conditions _____
(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? _____

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

23. Signature Albert H. Hoppe (M. D. or other) _____

Address Mo. Pac. Hosp. Date signed Mar 9, 47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

JUN 18 1947

26890

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. 3575

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, fact should be so stated above.