

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 11 1949

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11025**

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: DePaul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-weeks
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Lillie Wetzel

3. (b) If veteran, _____ name war _____

3. (c) Social Security No. _____

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced W. 2

6. (b) Name of husband or wife Fred J. Wetzel 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 29th., 1888
(Month) (Day) (Year)

8. AGE: Years 60 Months 4 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Oswald Lohse 4

13. Birthplace Germany 1
(City, town, or county) (State or foreign country)

14. Maiden name Mary C. Hohman

15. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Melvin A. Wetzel

(b) Address 4551 Nat'l. Bridge

17. (a) Burial (b) Date thereof 12-22-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine MO.

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindern Blvd.

19. (a) DEC 21 1948 (b) J. B. Rascher
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4551 Nat'l. Bridge
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19th., year 1948 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from 6-17-43 to 12-19-48, 19____; and that death occurred on the date and hour stated above.

that I last saw her alive on 12-19-48, 19____

Immediate cause of death _____
CORONARY-THROMBOSIS

Duration _____

Due to MYOCARDIAL-DEGENERATION
DIABETES

Due to HYPERTENSION

Other conditions _____
(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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature Joseph Nawrocki (M. D. or other) MD

Address 1961 Madison Date signed 12-20-48

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

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 H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.