

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18212**

FILED MAY 28 1949

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **865-**

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Shrewsbury		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Shrewsbury	
d. FULL NAME OF HOSPITAL OR INSTITUTION 7602 Weil Ave.		d. STREET ADDRESS (If rural, give location) 7602 Weil Ave.	

3. NAME OF DECEASED (Type or Print) ELIZABETH WALLHERMFECHTEL			4. DATE OF DEATH (Month) (Day) (Year) Apr. 9 1949		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov. 27, 1874	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 4 Days 12	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Westphalia, Mo.	12. CITIZEN OF WHAT COUNTRY? _____
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13a. FATHER'S NAME Henry Adrian	13b. MOTHER'S MAIDEN NAME Catherine Morfeld	14. NAME OF HUSBAND OR WIFE Late Herman Wallhermfechtel
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of abdomen (Multiple)		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Primary Carcinoma of breast DUE TO (c) 170x		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		50	

19a. DATE OF OPERATION July-1947	19b. MAJOR FINDINGS OF OPERATION carcinoma of left breast	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **4/13**, 19**42**, to **4/9**, 19**49**, that I last saw the deceased alive on **4/8**, 19**49**, and that death occurred at **7:20A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Arthur W. Westrup M.D.	23b. ADDRESS 204 E. Big Bend	23c. DATE SIGNED 4/9/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Apr. 12, 1949	24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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DATE REC'D BY LOCAL REG. 4-11-49	REGISTRAR'S SIGNATURE Theresa L. ...	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.
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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.

Signed Richard W. Stover and

Signed.....
Student Embalmer

Licensed Embalmer No. 4007

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.