

FILED OCT 26 1949

THE DIVISION OF HEALTH OF MISSOURI
DEATH CERTIFICATE

State File No. 33502

BIRTH NO. _____ REG. DIST. NO. 118 PRIMARY REG. DIST. NO. 4187 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN) <u>Union</u>	c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) <u>Union</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rural Route #2</u>		d. STREET ADDRESS (If rural, give location) <u>Rural Route #2</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) _____ c. (Last) <u>WETROFF Sr.</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 17 1949</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Aug. 4, 1860</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stationary Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Union, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME <u>Unknown Wetroff</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Late Annie Wetroff</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John Wetroff, Jr. 1514 Salerno Dr.</u>		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.		<u>6 1/2</u> <u>55 1/2</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 10-10, 1949 to 10-17, 1949, that I last saw the deceased alive on 10-15, 1949, and that death occurred at 8:30A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Th. Henry M.D.</u>	23b. ADDRESS <u>621 Oak St.</u>	23c. DATE SIGNED <u>10-17-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-20-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>
		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>

DATE REC'D BY LOCAL REG. <u>Oct. 17-1949</u>	REGISTRAR'S SIGNATURE <u>J. P. Cooper</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser 4228 S. Kingshighway Bl</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
10-25-49
District Health Officer No. 9
District File Number

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.

Student
Student Embalmer

Signed *Richard W. Stovand*

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.