

FILED JUN 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22154

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5281**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2033	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 1426 Walton Ave.		d. STREET ADDRESS (If rural, give location) 1404 Walton Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Arthur	b. (Middle) B.	c. (Last) Wimer	4. DATE OF DEATH (Month) (Day) (Year) June 15, 1950
---	-----------------------	------------------------	---

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar. 15, 1880	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 6 HRS. Hours	IF UNDER 15 MIN. Min.
--------------------	-------------------------------	---	---------------------------------------	---	---------------------------	--------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Decorator	10b. KIND OF BUSINESS OR INDUSTRY Interior Decor.	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	--	---

13a. FATHER'S NAME Ben Wimer	13b. MOTHER'S MAIDEN NAME Elizabeth Newsom	14. NAME OF HUSBAND OR WIFE Josephine M. Wimer
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Josephine M. Wimer-1404 Walton	ADDRESS
---	-------------------------	---	---------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH about 3-4 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) mitral insufficiency also stenosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? H/O X
---	--	--

22. I hereby certify that I attended the deceased from **June 3, 1945**, to **June 17, 1950**, that I last saw the deceased alive on **June 7, 1950**, and that death occurred at **10:45 Am.**, from the causes and on the date stated above.

23a. SIGNATURE A. M. Feldner M.D.	23b. ADDRESS 6203 Natural Bridge and	23c. DATE SIGNED 6/15/50
---	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 6/17/50	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
--	-----------------------------	---	---

DATE REC'D BY LOCAL REG. JUN 16 1950	REGISTRAR'S SIGNATURE J. B. Fasano	25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral - 1905 Union Blvd.	ADDRESS
--	--	---	---------

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

Dr. L. M. Feldaker
6203 Natural Bridge

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 Warren A. Carver

Licensed Embalmer No. 3534

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.