

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22977

State File No.

BIRTH NO. JUN 21 1952 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 546 Registrar's No. 1498

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY OR TOWN <u>Overland</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Overland</u> <u>436A</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>9425 Midland</u>		d. STREET ADDRESS (If rural, give location) <u>8721 Argyle</u> <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>H</u> c. (Last) <u>Wiewel</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 7 1952</u>
------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 4, 1867</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>11</u>	IF UNDER 12 HOURS Days <u>3</u>
--------------------	-------------------------------	-----------------------------------------------------------------------	--------------------------------------	-------------------------------------------	----------------------------------	---------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired foreman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Laclede Gas Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Quincy, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------	-------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <u>UNKNOWN Wiewel</u>	13b. MOTHER'S MAIDEN NAME <u>do NOT know</u>	14. NAME OF HUSBAND OR WIFE <u>Agnes T. Wiewel</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. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Agnes T. Wiewel</u> ADDRESS <u>8721 Argyle</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 yrs</u> <u>10 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Benignity</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 April 21, 1948, to 6/6/1952, that I last saw the deceased alive on 6/6/52, 1952, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr Arnold H. Warner M.D.</u> (Degree or title)	23b. ADDRESS <u>3115 Broivon Rd</u>	23c. DATE SIGNED <u>6/7/52</u>
------------------------------------------------------------------	-------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 9, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
---------------------------------------------------------	-------------------------------	---------------------------------------------------	--------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>6-8-52</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Dombke MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ortmann Funeral Home</u> ADDRESS <u>9222 Lackland</u>
----------------------------------------	---------------------------------------------------	-------------------------------------------------------------------------------------------

SW (Licensed Embalmer's Statement on Reverse Side)

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

box 1

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Al. C. Ortman

Signed.....
Student Embalmer

Licensed Embalmer No. 3478

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.