

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34701**

FILED OCT 2 - 1953

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2451

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 (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Johns</u>		c. CITY OR TOWN <u>St. Johns</u>	
c. LENGTH OF STAY (in this place) <u>3 yrs</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>8705-Ezra Avenue</u>		e. STREET ADDRESS (If rural, give location) <u>8705-Ezra Avenue</u>	

3. NAME OF DECEASED (Type or Print) <u>Viola Frances Vehlewald</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 14, 1953</u>		
a. (First)	b. (Middle)		c. (Last)	5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 2, 1922</u>	9. AGE (In years last birthday) <u>31</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Edwardsville, Ill.</u>	

13a. FATHER'S NAME <u>Ferdinand Schmidt</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Schaeke</u>		14. NAME OF HUSBAND OR WIFE <u>Robert Vehlewald</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>340-16-9159</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert Vehlewald 8705-Ezra Av-St. Johns</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Streptococcal meningitis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Cholecystitis of small bowel</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> <u>14 yrs.</u>	
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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) <u>153X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 Jan. 10, 1953, to Sept 14, 1953, that I last saw the deceased alive on Sept 12, 1953, and that death occurred at 5:30 P. M., from the causes and on the date stated above.

23a. SIGNATURE <u>Walter Gray</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>8938 S. Maple Road St. Louis 14 Mo</u>		23c. DATE SIGNED <u>9/16/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-17-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Park</u>	
24d. LOCATION (City, town, or county) (State) <u>Wellston, Mo.</u>					

DATE REC'D BY LOCAL REG. <u>9/16/53</u>		REGISTRAR'S SIGNATURE <u>Herbert B. Stankle MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Baumann Bros. Inc. 2504 Woodson Rd-Overland-14-Mo.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

Walter Gray St. Johns

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.....
Signature of Student Embalmer

Signed..... *David E. Gibson*

Licensed Embalmer No. *345*

P. O. Address *Conlan*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.