

FILED NOV 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39026

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9847**

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 OR TOWN St. Louis	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 79 yrs		e. STREET ADDRESS (If rural, give location) 16 3147a Michigan Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) c. (Last) Werder		4. DATE OF DEATH (Month) (Day) (Year) Nov. 10, 1955	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Mar. 16, 1876
9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME William Fricke	13b. MOTHER'S MAIDEN NAME Johanna	14. NAME OF HUSBAND OR WIFE Joseph Werder
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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. 488-10-0808B	17. INFORMANT'S SIGNATURE OR NAME Mrs. Chris Scherer	ADDRESS 3149 Michigan Avenue
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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 one week
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		
	ANTECEDENT CAUSES Arteriolar Nephrosclerosis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriolar Nephrosclerosis DUE TO (c) Generalized Arteriosclerosis		one year
II. OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Disease with Decompensation Conditions contributing to the death but not related to the disease or condition causing death.			two years
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) 442x
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 **10-18** ^{**1949**}, to **11-10**, 19**55**, that I last saw the deceased alive on **11-10**, 19**55**, and that death occurred at **8:40 P** m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title) M.D.	23b. ADDRESS 634 N. Grand Blvd.	23c. DATE SIGNED 11-11-55
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Nov. 14, 1955	24c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri

DATE REC'D BY LOCAL REG. NOV 12 1955	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE BEIDERWIEDEN F. H. INC.,	ADDRESS 1936 St. Louis Ave
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

Dr. John J. Roth
Mo. Theatre Bldg
Hours

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. *None* working under my personal supervision.

Student *None*
Signature of Student Embalmer

Signed *Delis J. Kispin*

Licensed Embalmer No. *349*

P. O. Address *St Louis*

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.