

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-16729  
STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 932

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1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>4000 Maryland Heights 0</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>County Hospital</b>		Length of stay in 1b <b>DOA</b>	d. STREET ADDRESS (If outside, give location) <b>Lindbergh Blvd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>RUDOLPH</b> Middle <b>W.</b> Last <b>WETTIG</b>			4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>1958</b>		
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5. SEX <b>male 0</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 26, 1903</b>	9. AGE (In years last birthday) <b>54</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>pharmacist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Co.</b>	11. BIRTHPLACE (City and state or country) <b>Illinois 1</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Herman Wettig</b>	13b. MOTHER'S MAIDEN NAME <b>Bertha Lehnhoff</b>	14. NAME OF HUSBAND OR WIFE <b>Wanita Winiker</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>unk.</b>	17. INFORMANT Address <b>Mrs. Wanita Wettig, Maryland Heights, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>unknown natural causes</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____	STATE _____
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Herbert R. Domke, MD</i> <b>Herbert R. Domke, MD, (Local Registrar)</b>	22b. ADDRESS <b>651 S. Brentwood, Clayton, Mo.</b>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>Apr. 3, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	23d. LOCATION (City, town, or country) (State) <b>St. Louis County, Mo.</b>
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24. FUNERAL DIRECTOR <b>BEIDERWIEDEN F.H. INC., 1936 St. Louis Av</b>	25. DATE RECD. BY LOCAL REG. <b>4-2-58</b>	26. REGISTRAR'S SIGNATURE <i>Herbert R. Domke, MD</i>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Embalmers

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 Delix J. Krupin

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.