

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031101
STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7784

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Centralia</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in lb <u>2 Weeks</u>	d. STREET ADDRESS (If outside, give location) <u>32. R. R.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MELVIN H. WESSEL</u>			4. DATE OF DEATH Month Day Year <u>AUGUST 9, 1958</u>		
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5. SEX <u>Male</u> <input checked="" type="checkbox"/>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1921</u>	9. AGE (In years last birthday) <u>37</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Good Dale Grocery Hoffman, Illinois</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Martin Wessel</u>	13b. MOTHER'S MAIDEN NAME <u>Amanda Rueder</u>	14. NAME OF HUSBAND OR WIFE <u>Gladys Wessel</u>
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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)	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Gladys Wessel, Centralia, Ill.</u>
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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) <u>UREMIA AND INTRACEREBRAL HEMORRHAGE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>POLYCYSTIC KIDNEY DISEASE</u>	<u>2 WEEKS</u>
	DUE TO (c) <u>757.1</u>	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>

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.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 AUG. 2, 1958 to AUG. 9, 1958 and last saw her/him alive on AUG. 9, 1958
Death occurred at 7:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>C. D. Nemillion, M.D.</u>	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>8/11/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug 10, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Centralia Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Centralia, Illinois</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Queen-Boggs, Centralia, Illinois</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 11 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Pearl Smith</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57
0

JAN 19 1959

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 *Leard Morris*

Licensed Embalmer No. *3760*

P. O. Address *St. Louis, Mo.*

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.