

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033317

STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 160 Primary Registration District No. 5592 Registrar's No. 133

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>JEFFERSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. CHARLES</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JOACHIM TOWNSHIP</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>O'FALLON, MO</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mt. View Nursing H.</b>			Length of stay in lb <b>2 yrs. 6 Mo</b>		d. STREET ADDRESS (If outside, give location) <b>P. R. # 1</b>		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>P.</b> Last <b>WEHMIER</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>8</b> Year <b>1958</b>					
5. SEX <b>MALE</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>MAR. 25, 1886</b>		9. AGE (In years last birthday) <b>72</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and state or country) <b>Kirkwood, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HERMAN WEHMIER</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
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>NONE</b>		17. INFORMANT Address <b>Mrs. Carrie Fehr, Cottleville Mo.</b>				
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>Coronary Thrombosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								DUE TO (b) _____	
DUE TO (c) _____								<b>4201</b>	
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? <b>2</b> YES <input type="checkbox"/> NO <input checked="" 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 _____ a. m. _____ p. m. Month _____ Day _____ Year _____									
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	
21. I attended the deceased from <b>2-21-56</b> to <b>9-8-58</b> and last saw <sup>her</sup> him alive on <b>9-8-58</b> Death occurred at <b>9:15 a.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Doctor or title) <b>R. A. [Signature]</b>				22b. ADDRESS <b>112 Mississippi Ave Crystal City, Mo.</b>				22c. DATE SIGNED <b>9-8-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9-10-58</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOLF CEMETERY</b>		23d. LOCATION (City, town, or county) <b>COTTLVILLE, MO.</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>KEITHLYS FUNERAL HOME, O'FALLON MO</b>				25. DATE RECD. BY LOCAL REG. <b>9-9-58</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

JEFFERSON COUNTY HEALTH DEPT.  
HILLSBORO, MISSOURI

DATE RECEIVED

SEP 1  
SEP 16 1958  
SEP 16 1958

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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 *James Richard Cady*.....

Licensed Embalmer No. *430*

P. O. Address *CRYSTAL*

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.