

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046494

STATE FILE NUMBER

12519

FILED JAN 12 1959		Registration District No. 318	Primary Registration District No. 1003	Registrar's No. 12519
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp.		Length of stay in 1b	d. STREET ADDRESS 2/1/58 Avalon Hotel 339 N Taylor	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Henry C Wertz			4. DATE OF DEATH Dec. 23, 1958 Month Day Year	
5. SEX M O W	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1869	9. AGE (In years at birthday) 89 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mississippi	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Dan Caffery Wertz		13b. MOTHER'S MAIDEN NAME Mary ?	14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 498-12-0403A	17. INFORMANT Address Mr. Robert D. Ehrhart Vicksburg, Miss	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Left Hip</i> <i>Arteriosclerosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>E903.7</i> DUE TO (c) <i>44</i>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Suffered in fall to floor</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Give nature of injury in PART I or PART II of item 18.) <i>at Chronic Hospital on December</i>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. 12 24 58 p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, school, street, office bldg., etc.) <i>13th Street</i>			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <i>St. Louis Mo</i>		COUNTY	STATE
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at <i>135 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>Carl Smith M.D.</i> (Degree or title)		22b. ADDRESS <i>1300 Clark Ave</i>		22c. DATE SIGNED <i>12-26-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>Dec. 27, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial park Cemetery</i>	23d. LOCATION (City, town, or county); <i>St. Louis Mo.</i> (State)	
24. FUNERAL DIRECTOR <i>Alexander & Sons Chapel</i>		25. DATE RECD. BY LOCAL REG. <i>DEC 26 58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL diseases in Part I must be causally related.

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 *Geo. E. McCallon*

Licensed Embalmer No. *2460*

P. O. Address *6145 Polina*

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.