Health, Welfare Public Service

300
1-56

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046499
STATE FILE NUMBER

JAN 12 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12214

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Alexian Bros Hosp — Length of stay in Hospital or Institution: 2 Days 27

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: St Louis
c. CITY OR TOWN: Mehlville 4000 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3616 Union Rd — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First William Middle W. Last Wetteroff
4. DATE OF DEATH: Month Dec. Day 16 Year 1958
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ / DIVORCED ☐
8. DATE OF BIRTH: Aug 3rd 1871
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months 4, Days 13 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Brick Mason
11. BIRTHPLACE (City and state or country): St Louis Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Wetteroff
14. MOTHER'S MAIDEN NAME: UNkown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 497-16-2547
17. INFORMANT: Mrs Mary Wetteroff — Address: 3616 Union Rd Mehlville Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of bladder & prostate with metastasis.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1992
INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Feb 55, to Dec 15 and last saw her/him alive on Dec 15-58
Death occurred at 6:45 a m/p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Stephen M. Popper M.D.
22b. ADDRESS: 3720 Washington
22c. DATE SIGNED: Dec 18-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Dec 19 1958
23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
23d. LOCATION (City, town, or county) (State): Affton Mo.

24. FUNERAL DIRECTOR ADDRESS: Fey Funeral Home, Mehlville Mo.
25. DATE RECD. BY LOCAL REG.: DEC 18 '58
26. REGISTRAR'S SIGNATURE: J Carl Smith M.D. acm

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed V. E. Morris

Licensed Embalmer No. 33

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.