

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001163

STATE FILE NUMBER

FILED FEB 9 1959

Registration District No. 142 Primary Registration District No. 5556 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mountain View</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Willow Springs</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>		Length of stay in 1b <u>3 Days</u>	d. STREET ADDRESS (If outside, give location) <u>Gen. Delivery</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>H.</u> Last <u>WEHRLI</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>25</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1870</u>	9. AGE (In years last birthday) <u>88</u> Months <u>9</u> Days <u>24</u>	IF UNDER 1 YEAR Hours <u>24</u> Min.	IF UNDER 24 HRS. Hours <u>24</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Chicago, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jacob Wehrli</u>	13b. MOTHER'S MAIDEN NAME <u>Abbie Roberts</u>	14. NAME OF HUSBAND OR WIFE <u>-Abbie Gale Wehrli</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) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Cecil Cacka, 2525 N. 63rd St.</u>	Address
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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>Cerebral Embolism</u> <u>Omaha, Nebr.</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocarditis</u>	
	DUE TO (c) <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? 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.)
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20c. TIME OF INJURY Hour <u>8:15</u> Month <u>1</u> Day <u>21</u> Year <u>1959</u> a.m. p.m.	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 <u>Willow Springs, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from <u>1/21/59</u> to <u>1-25-59</u> and last saw her alive on <u>1-25-59</u> Death occurred at <u>8:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H.W. Miller, M.D.</u>	22b. ADDRESS <u>Willow Springs, Mo.</u>	22c. DATE SIGNED <u>1/27/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>	23d. LOCATION (City, town, or county) (State) <u>Lincoln, Nebr.</u>
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24. FUNERAL DIRECTOR <u>Burns Funeral Home, Willow Spgs., Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-2-59</u>	26. REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>
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1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

FEB 9 1959

FEB 17 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

Thomas R. Burns

Signed Thomas R. Burns

Licensed Embalmer No. 4214
P. O. Address Willow Springs,

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.