

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007775

STATE FILE NUMBER

2 2042

FILED MAR 10 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>LESLIE</b> <i>0-360</i> 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>DEACONESS HOSP.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>LYON TOWNSHIP</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>HENRY</b> Last <b>WERGES</b>			4. DATE OF DEATH Month <b>FEB.</b> Day <b>25</b> Year <b>1959</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>MARCH 25, 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	9. AGE (In years at birthday) <b>77</b> IF UNDER 1 YEAR: Months <b>9</b> IF UNDER 24 HRS.: Days _____ Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>HANOVER, GERMANY 4</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOHN WERGES</b>		13b. MOTHER'S MAIDEN NAME <b>ELIZA SCHROEDER</b>	
14. NAME OF HUSBAND OR WIFE (ANNA) <b>MRS. HERMAN WERGES</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>493-42-7244</b>		17. INFORMANT Address <b>MRS. WILMA HENNEKE LESLIE, 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>Brain Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Rupture of arteriosclerotic cerebral artery</b> DUE TO (c) <b>331X</b>			<b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic hypertensive cardiovascular disease</b>			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.)	
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>2-19-59</b> to <b>2-25-59</b> and last saw her alive on <b>2-25-59</b> Death occurred at <b>2:00 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>[Signature]</i> M.D.		22b. ADDRESS <b>634 N. Grand Blvd.</b>	22c. DATE SIGNED <b>2-26-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>FEB. 28, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ZION METHODIST CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>LESLIE, MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>OLTMANN FUNERAL HOME GERALD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 26 '59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M.D. <i>WBE</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ralph Altman* .....

Licensed Embalmer No. *4808* .....

P. O. Address *Union, 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.