

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011906
STATE FILE NUMBER

AR 19 1959

Registration District No. 517

Primary Registration District No. 500

Registrar's No. 694

1. PLACE OF DEATH a. COUNTY <u>St. Louis Co</u> <u>Normandy Pater. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORMANDY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>4356 University City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Pater. Hosp.</u>		Length of stay in 1b <u>1 day</u>	d. STREET ADDRESS (If outside, give location) <u>6843 A Crest</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>IRMA MARIE WIESEN BORN</u>			4. DATE OF DEATH Month Day Year <u>3 - 15 - 1959</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-1924</u>		9. AGE (In years last birthday) <u>35</u>	10. FUNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>club</u> <u>Stymie Supper Miami</u>		11. BIRTHPLACE (City and state or country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Arthur J. Steinke</u>		13b. MOTHER'S MAIDEN NAME <u>Bessie C. Fischer</u>		14. NAME OF HUSBAND OR WIFE <u>Roy Wiesenborn</u>			

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>494-16-1386</u>		17. INFORMANT Address <u>HR Roy W. WIESEN BORN 6843A CREST AVE</u>			
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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>Respiratory paralysis</u> Interval between onset and death <u>minutes</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Increased intracranial pressure</u> Interval between onset and death <u>minutes</u>	
	DUE TO (c) <u>Cerebral embolism</u> Interval between onset and death <u>Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>Subacute Bacterial Endocarditis</u> <u>4360</u>		

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.						

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 <u>Jan. 1959</u> to <u>March 15, 1959</u> and last saw her/him alive on <u>March 15, 1959</u> Death occurred at <u>1:20 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE <u>Robert L. Owen</u> (Degree or title) <u>D.O. 2</u>		22b. ADDRESS <u>75876 Olive Blvd St Louis 5 Mo.</u>		22c. DATE SIGNED <u>3-15-59</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3/18/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO.</u>	
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24. FUNERAL DIRECTOR <u>C.R. UPTON AND SONS</u>		ADDRESS <u>7233 Delmar Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>3-16-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>	
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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 *Clarence A. Murr*

Licensed Embalmer No. *4911*.....

P. O. Address *St. Louis*.....

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.