

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016379
STATE FILE NUMBER

FILED APR 27 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1052

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SAPPINGTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MEHLVILLE</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>GRAVOIS REST HAVEN</u> Length of stay in 1b <u>3 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>RT 8-Box 340 HAWKINS MO</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>PAULINE - WESTERMANN</u>			4. DATE OF DEATH Month Day Year <u>APRIL - 17 - 1959</u>		
5. SEX <u>FEMALE</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>JUNE-28-1878</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>9 20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>GERMANY 4</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GODFRIED WUEFLER</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>LYDIA C. SCHROETER</u> Address <u>78-Box 340 HAWKINS MO</u>		

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>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>		
DUE TO (c) <u>Seriousity</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left hip Mar. 12, 59</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.) <u>Fell in bathroom of home 3/12/59</u>	
20c. TIME OF INJURY Hour a. m. p. m. <u>3/12/59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>
20f. CITY, TOWN, OR LOCATION <u>Lemay mo.</u>		20g. COUNTY <u>Lemay</u>
21. I attended the deceased from <u>Mar. 3 1954</u> to <u>Apr 17, 59</u> and last saw her alive on <u>Apr 16, 59</u> Death occurred at <u>6:30 A. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>John C. Murphy M.D.</u> (Degree or title)	22b. ADDRESS <u>7702 Lemay Ave</u>	22c. DATE SIGNED <u>4/17/59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Apr-20-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old St Johns Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>MEHLVILLE MO</u>
24. FUNERAL DIRECTOR <u>Fey Funeral Home</u> ADDRESS <u>MEHLVILLE</u>	25. DATE RECD. BY LOCAL REG. <u>Mo 4-19-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
700-56
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.....

Licensed Embalmer No.

P. O. Address.....

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