

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022430

STATE FILE NUMBER

FILED JUN 24 1959

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 95

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>BOULDS HANNA</u> OP		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LOUISIANA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>PIKE CO HOSPITAL</u>		Length of stay in 1b <u>65 years</u>	d. STREET ADDRESS (If outside, give location) <u>415 NO 42 S. ST.</u> 0821

3. NAME OF DECEASED (Type or print) First <u>FLORA</u> Middle <u>LOUISE</u> Last <u>WEHRMAN</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>16</u> Year <u>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 22, 1874</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 MAKING</u>	11. BIRTHPLACE (City and state or country) <u>ONTARIO CANADA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	

13a. FATHER'S NAME <u>E. U. Whipple</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Brazie</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>		16. SOCIAL SECURITY NO. <u>H97-01-0389D</u>		17. INFORMANT <u>Edward Wehrman, Evansville Ind</u> Address	

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>Uremia</u> <u>Cerebral vascular accident</u> 1st " " " " " " " " 2nd Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic cardio-vascular renal disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 1/2 months</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>442X</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.) -----		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		-----		

20d. INJURY OCCURRED WHILE AT <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 -----
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21. I attended the deceased from 1950 to 6/16/59 and last saw her alive on 6-15-59  
Death occurred at 3111 A on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Chris H. Swellin M.D.</u>	22b. ADDRESS <u>Louisiana, Missouri</u>	22c. DATE SIGNED <u>6-17-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 18, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>River View</u>	23d. LOCATION (City, town, or county) (State) <u>Louisiana Mo.</u>
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24. FUNERAL DIRECTOR <u>Sterner</u>	ADDRESS <u>Louisiana Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>June 22. 59</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Culver</u>
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(Licensed Embalmer - Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *J. B. Sterne* .....

Licensed Embalmer No. *4039* .....

P. O. Address *Louisiana* .....

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.