

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026292

FILED VS AUG 10 1959

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 185 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	<u>St. Charles</u>	a. STATE	<u>Missouri</u> b. COUNTY <u>St. Charles</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	<u>St. Charles</u>	c. CITY OR TOWN	<u>St. Charles</u>
	Length of stay in lb <u>32 days</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>St. Joseph</u>	d. STREET ADDRESS (If outside, give location)	<u>1208 N. Third St.</u>
	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Irene</u>	Middle <u>Jane</u>	Last <u>Werremeyer</u>	4. DATE OF DEATH	Month <u>Aug.</u>	Day <u>5,</u>	Year <u>1959</u>
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5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
<u>Female</u>	<u>White</u>		<u>Oct. 10, 1895</u>	<u>63</u>	Months <u>9</u>	Days <u>26</u> Hours <u></u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
<u>Housewife</u>	<u>Own Home</u>	<u>O'Fallon, Mo.</u>	<u>U.S.A.</u>

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
<u>George Bailey</u>	<u>Susan Harmon</u>	<u>Walter Werremeyer</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<u>No</u>	<u>None</u>	<u>Mrs. Carl Echele,</u>	<u>St. Charles, Mo.</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Pneumonia - Cerebral Vascular Accident</u>	<u>few weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <u>Hypertension - Atherosclerosis</u>	<u>years</u>
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days.
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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></u> Month, Day, Year <u></u>
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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
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21. I attended the deceased from July 4 to Aug. 5 and last saw her him alive on Aug 5, 1959
 Death occurred at 10³⁰ p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED
<u>O.K. Thiel n.d</u>		<u>3003 N. Main St. Charles, Mo.</u>	<u>8/6/59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug. 8, 1959</u>	<u>Oak Grove Cemetery</u>	<u>St. Charles County, Mo.</u>

24. FUNERAL DIRECTOR	ADDRESS	Mo.	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<u>H.C. Dallmeyer & Sons,</u>	<u>St. Charles,</u>	<u>Mo.</u>	<u>Aug 6-59</u>	<u>Marcella Wilson</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1988

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Frank R. Rama

Licensed Embalmer No. 48

P. O. Address St. Charles

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