

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034607

FILED VS SEP 28 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2498 STATE FILE NUMBER

ENDED

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> COUNTY <u>ST LOUIS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Length of stay in 1b <u>HRS</u>		c. CITY OR TOWN <u>LEMAY</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>COUNTY HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>224 LEMAY FERRY</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK J WERNET</u>				4. DATE OF DEATH Month Day Year <u>9 17 1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12/10/97</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARTENDER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>TAVERN</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JACOB WERNET</u>			13b. MOTHER'S MAIDEN NAME <u>WILHELMINA PRIFER</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO NONE</u>			16. SOCIAL SECURITY NO. <u>498-09-8352</u>		17. INFORMANT Address <u>JACOB WERNET 7507 VIRGINIA</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>UREMIA</u> DUE TO (b) <u>ACUTE PYELONEPHRITIS.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>TRACHEOBRONCHITIS, ACUTE CONGESTION GASTRIC DILATATION BOTH LUNGS.</u>								
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.)				
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 <u>9-16-1959</u> to <u>9-17-1959</u> and last saw ^{her} him alive on <u>9-17-1959</u> Death occurred at <u>439p.m</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Ronald C. Dossman M.D.</u>				22b. ADDRESS <u>601 S. BRENTWOOD BLVD</u>			22c. DATE SIGNED <u>9-18-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9/21/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE GEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>LEMAY MISSOURI</u>			
24. FUNERAL DIRECTOR ADDRESS <u>FENDLER UNDC. 7420 MICHIGAN</u>			25. DATE RECD. BY LOCAL REG. <u>SEP 25 1959</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 W. G. Peters

Licensed Embalmer No. 3767

P. O. Address 7420 Michigan

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.