

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012176

AMENDED FILED APR 10 1961 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 846 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH  
 a. COUNTY ST LOUIS  
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON Length of stay in 1b  
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION COUNTY HOSPITAL Inside Limits Yes  No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
 a. STATE MO b. COUNTY ST LOUIS  
 c. CITY OR TOWN OVERLAND Inside Limits Yes  No   
 d. STREET ADDRESS (If outside, give location) 2514 GASS Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year  
WILLIAM JESSE WERNER MAR. 26 1961

5. SEX MALE 6. COLOR OR RACE W 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH 11/8/1893 9. AGE (last birthday) 77  
 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) BRICK LAYER (RETIRED) 10b. KIND OF BUSINESS OR INDUSTRY BUILDING 11. BIRTHPLACE (City and state or country) ILLINOIS 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME EMIL WERNER 13b. MOTHER'S MAIDEN NAME \_\_\_\_\_ 14. NAME OF HUSBAND OR WIFE STELLA WERNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO 17. INFORMANT Address ROBERT RYAN 2514 GASS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Bronchopneumonia bilateral INTERVAL BETWEEN ONSET AND DEATH 2 weeks  
 DUE TO (b) \_\_\_\_\_  
 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) generalized arteriosclerosis Postoperative wound right hip infected (3 months)  
 PART III. If deceased was female was there a pregnancy in last 90 days.  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT  SUICIDE  HOMICIDE  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  NOT WHILE AT WORK  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 2-28-61 to 3-26-61 and last saw her/him alive on 3-26-61  
 Death occurred at 12:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul W. Schaper M.D. 22b. ADDRESS 601 S. Brentwood Clayton, Mo. 22c. DATE SIGNED 3-28-61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 3/29/61 23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL 23d. LOCATION (City, town, or county) (State) Page Dale, MO

24. FUNERAL DIRECTOR EARL HILLEMANN ADDRESS OVERLAND, MO 25. DATE RECD. BY LOCAL REG. 3/28/61 26. REGISTRAR'S SIGNATURE John C. Murphy, Md.

**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. (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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **846**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CLAYTON</b>		c. CITY OR TOWN <b>OVERLAND</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CO HOSPITAL</b>		d. STREET ADDRESS <b>2514 GASS</b>	

3. NAME OF DECEASED (Type or print) **WILLIAM JESS E WERNER**  
First Middle Last

4. DATE OF DEATH **MAR 26 1961**  
Month Day Year

5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-9-1983</b>	9. AGE (In years last birthday) <b>77</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>BRICKLAYER</b>	11. BIRTHPLACE (City and state or country) <b>ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13. FATHER'S NAME **EMIL WERNER**

14. MOTHER'S MAIDEN NAME \_\_\_\_\_

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **NO**

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT \_\_\_\_\_ 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) **Broncho-pneumonia bilateral**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) \_\_\_\_\_ DUE TO (c) \_\_\_\_\_

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Generalized Arteriosclerosis**

INTERVAL BETWEEN ONSET AND DEATH **2 days**

19. WAS AUTOPSY PERFORMED? YES  NO

20a. ACCIDENT  SUICIDE  HOMICIDE

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  NOT WHILE AT WORK

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 **2-28-61** to **3-26-61** and last saw <sup>met</sup>him alive on **3-26-61**  
 Death occurred at **12:22 p** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Paul W Schaper MD**

22b. ADDRESS **601 S. Brentwood, Clayton, Mo.**

22c. DATE SIGNED **3/28/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL**

23b. DATE **3-29-61**

23c. NAME OF CEMETERY OR CREMATORY **LAUREN HILL**

23d. LOCATION (City, town, or county) (State) **PAGE DALE MISSOURI**

24. FUNERAL DIRECTOR **EARL HILLEMANN** ADDRESS **OVERLAND MO**

25. DATE RECD. BY LOCAL REG. **3-28-61**

26. REGISTRAR'S SIGNATURE \_\_\_\_\_

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STATEMENT BY LICENSED EMBALMER

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

Student.....  
Signature of Student Embalmer

Signed *Eme J. Allen*

Licensed Embalmer No. ....

P. O. Address *Greer*

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.