SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-043020
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10574

FILED NOV 28 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Deaconess 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: Creve Coeur — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): Rt.1; Box 463 Mason Rd. & Hiway 40 — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First CARL Middle E. Last WERNER

4. DATE OF DEATH: Month NOV. Day 12, Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 2-15-1903

9. AGE (last birthday): 58 — 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): Retired-Comptroller

10b. KIND OF BUSINESS OR INDUSTRY: Socony-Vacuum Oil Co. St. Louis, Mo.

11. BIRTHPLACE (City and state or country): U.S.A.

12. CITIZEN OF WHAT COUNTRY:

13a. FATHER'S NAME: Edward Werner

13b. MOTHER'S MAIDEN NAME: Jeannette Godfrey

14. NAME OF HUSBAND OR WIFE: Juanita B. Werner

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

16. SOCIAL SECURITY NO.:

17. INFORMANT: Juanita B. Werner, Rt.1; Box 463 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): HEPATIC COMA — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): CIRRHOSIS OF LIVER — 9 Mo's.

DUE TO (c): 581.0

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. ☐ 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 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 1.21.61, to 11.12.61 and last saw ~~her~~ him alive on 11.12.61

Death occurred at 11.12.61 3:30P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert E Koch M.D.

22b. ADDRESS: 35 N. Central

22c. DATE SIGNED: 11-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 11-15-1961

23c. NAME OF CEMETERY OR CREMATORY: St. Peter's Cem.

23d. LOCATION (City, town, or county) (State): Normandy, Mo.

24. FUNERAL DIRECTOR — ADDRESS: Kriegshauser 9450 Olive St. Rd.

25. DATE RECD. BY LOCAL REG.: NOV 14 1961

26. REGISTRAR'S SIGNATURE: Karl Smith. M.D.

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4533

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.