

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043023

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

11044

STATE FILE NUMBER

AMENDED

Registration District No. FILED DEC 1 1961

Primary Registration District No.

Registrar's No.

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		c. CITY OR TOWN <u>KIRKWOOD</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STONE NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>116 BRENT</u>	
Inside Limits Yes <input 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 Middle Last <u>CATHERINE LUCILLE WETTON</u>			4. DATE OF DEATH Month Day Year <u>NOV 26 1961</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>JAN 21 1886</u>
9. AGE (last birthday) <u>75</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>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO</u>
12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>		13a. FATHER'S NAME <u>GEORGE GEISSERT</u>	
13b. MOTHER'S MAIDEN NAME <u>NORA SHEEHY</u>		14. NAME OF HUSBAND OR WIFE <u>EDWARD M WETTON</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>NONE</u>	
17. INFORMANT <u>EDWARD M WETTON</u>		Address <u>116 BRENT</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>CEREBRAL HEMORRHAGE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovasc. Disease</u>			<u>2 yr +</u>
DUE TO (c) <u>443x</u>			
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 checked="" 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>MARCH 2, 1961</u> to <u>NOV. 26, 61</u> and last saw her <u>her</u> alive on <u>NOV. 25, 1961</u> Death occurred at <u>2 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Raymond T. Martin MD</u>		22b. ADDRESS <u>5203 Chippewa St.</u>	22c. DATE SIGNED <u>11-27-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>NOV 28 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kutis 2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 28 1961</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>

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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 embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Corley H. Hays Jr.

Licensed Embalmer No. 4861

P. O. Address: Blairton, Md.

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.