

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 12779-10580

12779
10580

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2309 So. 4th St.</u>		d. STREET ADDRESS (If rural, give location) <u>2309 So. 4th St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Elizabeth</u> b. (Middle) _____ c. (Last) <u>Minneman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 7 1949</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>Dec. 7, 1872</u>		9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		
11. BIRTHPLACE (State or foreign country) <u>St. Louis MO</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		

13a. FATHER'S NAME <u>Martin Berkemeier</u>		13b. MOTHER'S MAIDEN NAME <u>Theresa Harder</u>		14. NAME OF HUSBAND OR WIFE <u>Henry Minneman</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>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clara Minneman, 2309 So. 4th St.</u>	
--	--	-----------------------------------	--	---	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Disease</u>				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chr. Valvular Disease</u>					
		DUE TO (c) <u>Hypertension</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	----------------------------------	--	--	--	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>102</u>	
--	--	--	--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4222</u>	
---	--	---	--	--	--

22. I hereby certify that I attended the deceased from 11/26, 1949, to 12/7, 1949, that I last saw the deceased alive on 12/6, 1949, and that death occurred at 9:15A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Wagonbach M.D.</u> (Degree or title)		23b. ADDRESS <u>4717 Morganford</u>		23c. DATE SIGNED <u>12/8/49</u>	
--	--	-------------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 10, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
---	--	--------------------------------	--	--	--	---	--

DATE REC'D BY LOCAL HEALTH DEPT. <u>DEC 9 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Karater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hoffmeister Colonial Mortuary 6464 Chippewa St.</u>	
--	--	--	--	---	--

ONLY—USING UNEARLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. W. F. Wackenbach
4717 Morganford Rd.

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
Student Embalmer

Signed *Louis C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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 this body is not embalmed, fact should be so stated above.