

FILED APR 20 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14299

State File No. 3177

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	2139
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If rural, give location) 5400 Arsenal	

3. NAME OF DECEASED (Type or Print) Theresa H. Holcombrink			4. DATE OF DEATH (Month) (Day) (Year) March 31 1951		
a. (First)	b. (Middle)	c. (Last)			

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 4, 1886	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Middletown, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Frank Porter	13b. MOTHER'S MAIDEN NAME Martha (Unknown)	14. NAME OF HUSBAND OR WIFE Daniel P. Holcombrink
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Daniel Holcombrink, 809 N. Grand Bl.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 9/18x
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	DUE TO (c)		
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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200
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22. I hereby certify that I attended the deceased from Jan. 1, 1949, to March 31, 1951, that I last saw the deceased alive on Mar. 31, 1951, and that death occurred at 8:00a m., from the causes and on the date stated above.

23a. SIGNATURE Jack Ridelman MD	(Degree or title)	23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 3/31/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/3/51	24c. NAME OF CEMETERY OR CREMATORY Louisiana, Mo.	24d. LOCATION (City, town, or county) (State) Louisiana, Missouri
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DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE J. B. Lancaster	25. FUNERAL DIRECTOR'S SIGNATURE PROVOST UND. CO., 3710 N. Grand Bl.	ADDRESS
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Albert Mayfield

Signed.....
Student Embalmer

Licensed Embalmer No. 3077

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