

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31193

State File No.

FILED SEP 19 1951

BIRTH NO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. <u>178</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>			
b. CITY OR TOWN <u>St. Charles</u>		c. LENGTH OF STAY (in this place) <u>10 days</u>		c. CITY OR TOWN <u>St. Peters</u>		<u>0920</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>none</u>			
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Iffrig</u>			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 5, 1951</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>June 28 1872</u>		9. AGE (In years last birthday) <u>79</u>	Months <u>2</u>	Days <u>7</u>
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 <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>St. Peters, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Frank Wiechens</u>		13b. MOTHER'S MAIDEN NAME <u>-- Algermissen</u>		14. NAME OF HUSBAND OR WIFE <u>Aloys Iffrig</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'S SIGNATURE OR NAME ADDRESS <u>Robt. Iffrig, St. Peters, Mo.</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</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 <u>331x</u>					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)				
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?				
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>40</u> , to <u>Sept 5, 1951</u> , that I last saw the deceased alive on <u>Sept 5</u> , 19 <u>51</u> , and that death occurred at <u>8:20 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u> Vincent A. Helmerick M.D.</u>				23b. ADDRESS <u>St. Charles, Mo.</u>		23c. DATE SIGNED <u>Sept 7-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-8-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Peters, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>9-8-51</u>	REGISTRAR'S SIGNATURE <u>Francis Helmerick</u>		28c. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. Stiefater</u>		ADDRESS <u>St. Peters Mo.</u>		

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

0923
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File No. _____
DISTRICT HEALTH OFFICE No. 4

SEP 17 1951

RECEIVED

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 *E. A. Keithley*

Licensed Embalmer No. *822*

P. O. Address *Fallon mo*

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.