

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36458**
Registrar's No. **9384**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2159	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5157 Cologne		d. STREET ADDRESS (If rural, give location) 15 5157 Cologne	

3. NAME OF DECEASED (Type or Print) a. (First) Ida b. (Middle) G. c. (Last) Heberer	4. DATE OF DEATH (Month) (Day) (Year) 10/10/52
-------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 28, 1884	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Stanton, Texas		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Michael Ohlman	13b. MOTHER'S MAIDEN NAME Catherine Jacobberger	14. NAME OF HUSBAND OR WIFE Otto J.
------------------------------------------	--------------------------------------------------------	--------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Dorothy Syberg-5157 Cologne	ADDRESS
--------------------------------------------------------------------------------------------------------------------	-------------------------------------	----------------------------------------------------------------------	---------

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		INTERVAL BETWEEN ONSET AND DEATH 1 Day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocarditis, Ch. Arterio-Scl, Heart disease DUE TO (c) Hypertension		
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)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200
--------------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------------------

22. I hereby certify that I attended the deceased from **9/8, 1952** to **10/9, 1952**, that I last saw the deceased alive on **10/8, 1952**, and that death occurred at **12:15 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. Wagler M.D.	23b. ADDRESS 4717 Morganford	23c. DATE SIGNED 10/10/52
--------------------------------------------------------	-------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/13/52	24c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchvard	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
----------------------------------------------------------	---------------------------	----------------------------------------------------------------	------------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. OCT 11 1952	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Keller	ADDRESS 3634 Gravois
---------------------------------------------	--------------------------------------------------	-------------------------------------------------------	-----------------------------

S.P. (Licensed Embellisher's Statement on Reverse Side)

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

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 Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address Kenosha 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.