

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33512**
9495

FILED OCT 15 1953

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Desloge Hospital		d. STREET ADDRESS (If rural, give location) 1014 Oak View Place	

3. NAME OF DECEASED (Type or Print)	a. (First) Harriet	b. (Middle) Wieselman	c. (Last) Joynson	4. DATE OF DEATH (Month) (Day) (Year) Oct. 24, 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 28, 1889	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 7 Days 3	IF UNDER 24 hrs. Hour 3 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Max Wieselman	13b. MOTHER'S MAIDEN NAME Sarah Ottman	14. NAME OF HUSBAND OR WIFE Lee Joynson
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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. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Lee Joynson-1014 Oak View Place
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Septicemia Staphylococcus		INTERVAL BETWEEN ONSET AND DEATH 18 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes mellitus		
	DUE TO (c) Hypostatic Pneumonia		
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 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 260X
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22. I hereby certify that I attended the deceased from **Sept 1, 1953**, to **Oct 3, 1953**, that I last saw the deceased alive on **Oct 3, 1953** and that death occurred at **7:10 p.m.**, from the causes and on the date stated above.

22a. SIGNATURE Michael J. Lohrecks MD (Degree or title)	22b. ADDRESS 931 Marconi	22c. DATE SIGNED 10-3-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/4/53	24c. NAME OF CEMETERY OR CREMATORY Closed Shel Emeth Cem, St. Louis County, Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. OCT 5 1953	REGISTRAR'S SIGNATURE Charles Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman Rindskopf, Inc., 5212 Delmar
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(Licensed Embalmer's Statement on Reverse Side)

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

2-286

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 Peter B. Dehoulliet

Licensed Embalmer No. 3691

P. O. Address Palmer, Me

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.