

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37261

FILED NOV 6 - 1953

State File No. 10080

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		REGISTRAR'S NO. 10080	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE MISSOURI b. COUNTY ST. LOUIS			
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 PINE LAWN 1161		d. STREET ADDRESS (If rural, give location) 21 BLAKEMORE	
d. FULL NAME OF HOSPITAL OR INSTITUTION DEPAUL HOSPITAL							
3. NAME OF DECEASED (Type or Print) a. (First) MINNIE		b. (Middle)		c. (Last) HERWEG		4. DATE OF DEATH (Month) (Day) (Year) OCT, 20, 1953	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 11/12/1878	
9. AGE (In years; last birthday) 74		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY					
13a. FATHER'S NAME JOHN F KRAEMER		13b. MOTHER'S MAIDEN NAME FREDERICKA HENRICKS		14. NAME OF HUSBAND OR WIFE CLEMENT HERWEG			
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 CLEMENT HERWEG 21 BLAKEMORE PL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy						20 days	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
DUE TO (b) Previous attacks of cerebral apoplexy since 1952							
DUE TO (c) Fractured right hip						9/30/53	
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) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9-30-53 12:10		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell at home.		334XF	
22. I hereby certify that I attended the deceased from 9/22/52 , 19___, to 10/20/53 , 19___, that I last saw the deceased alive on 10/20 , 19 53 , and that death occurred at 11:20 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) F.R. Ferguson M.D.				23b. ADDRESS 539 No. Grand Blvd.		23c. DATE SIGNED 10/22/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 10/24/53		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI	
DATE REC'D BY LOCAL REG. OCT 22 1953		REGISTRAR'S SIGNATURE G. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STROOT - CARROLL 4600 NATURAL BRDG			

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

E-061

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 M E Ruster

Licensed Embalmer No. 4865

P. O. Address St Louis 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.