

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

45352

FILED JAN 19 1954

State File No. \_\_\_\_\_

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 12284

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>                  /                  </u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>                  </u> b. COUNTY <u>                  </u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>                  </u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>                  </u>		2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>                  </u>				d. STREET ADDRESS (If rural, give location) _____			
1253 Sells Ave.				10 4533A Ashland Ave. 0			
3. NAME OF DECEASED a. (First) <u>                  </u> b. (Middle) <u>                  </u> c. (Last) <u>                  </u>			4. DATE OF DEATH (Month) (Day) (Year)				
Minnie Helbig			Dec. 27th, 1953				
5. SEX <u>                  </u>	6. COLOR OR RACE <u>                  </u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>                  </u>	8. DATE OF BIRTH <u>                  </u>		9. AGE (In years last birthday) <u>                  </u>	10. MONTHS <u>                  </u>	11. DAYS <u>                  </u>
Female	White	Widowed	2 Aug. 16th, 1865		88		
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>                  </u>			10b. KIND OF BUSINESS OR INDUSTRY <u>                  </u>		11. BIRTHPLACE (State or foreign country) <u>                  </u>		12. CITIZEN OF WHAT COUNTRY? <u>                  </u>
Housewife					Oakaville, Ill		
13a. FATHER'S NAME <u>                  </u>			13b. MOTHER'S MAIDEN NAME <u>                  </u>		14. NAME OF HUSBAND OR WIFE <u>                  </u>		
Henry Hokamp			Anna Schasiack		Oscar Helbig		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>                  </u>		16. SOCIAL SECURITY NO. <u>                  </u>		17. INFORMANT'S SIGNATURE OR NAME <u>                  </u> ADDRESS <u>                  </u>			
None		No		Alma Thirolf (Daughter) 4533A Ashland Ave.			
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>                  </u>		Cerebral thrombosis			
		ANTECEDENT CAUSES		DUE TO (b) <u>                  </u>			
				Generalized arteriosclerosis			
				DUE TO (c) <u>                  </u>			
		II. OTHER SIGNIFICANT CONDITIONS					
				Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>                  </u>		19b. MAJOR FINDINGS OF OPERATION <u>                  </u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>                  </u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>                  </u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>                  </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) <u>                  </u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>                  </u>			
				332X			
22. I hereby certify that I attended the deceased from <u>                  </u> to <u>                  </u> , that I last saw the deceased alive on <u>                  </u> , 1953, and that death occurred at <u>                  </u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>                  </u>				23b. ADDRESS <u>                  </u>		23c. DATE SIGNED <u>                  </u>	
Herbert H. Slesener MD				6000 W. Florissant		12/28/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>                  </u>		24b. DATE <u>                  </u>	24c. NAME OF CEMETERY OR CREMATORY <u>                  </u>		24d. LOCATION (City, town, or county) (State) <u>                  </u>		
Burial		12/31/53	Friedens		St. Louis, Mo.		
DATE REC'D BY LOCAL REG. <u>                  </u>		REGISTRAR'S SIGNATURE <u>                  </u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>                  </u>			
DEC 29 1953		Carl Smith MD		Kraeger Funeral Home 3402 N. Kingshigh way			

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 Me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

W. Wilkinson

Licensed Embalmer No. \_\_\_\_\_

3570

P. O. Address \_\_\_\_\_

M. 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.