

FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28534

STATE FILE NUMBER

318

1003

Registrar's No. 6809

Registration District No. Primary Registration District No.

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If outside, give location) 5091 Cates Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Margie Herchenbach			4. DATE OF DEATH Month Day Year July 18, 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	9. AGE (In years last birthday) 53
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
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 Address P.W. Herchenbach (husband) 5091 Cates Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arachnoiditis</i> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pathy metamorphoses, liver</i>			INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 491x		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from 7-16-56 to 7-18-56 and last saw her her alive on 7-18-56 Death occurred at 3:20p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Leroy F. Whiteaker M.D.</i>	22b. ADDRESS 1515 Lafayette	22c. DATE SIGNED 7-20-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-23-56	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Chas. F. Stuart	ADDRESS 1225 Union Blvd.	25. DATE RECD. BY LOCAL REG. JUL 20 1956	26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300-1-56 0
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 Melvin L. Kempfer, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Melvin L. Kempfer

Licensed Embalmer No. 40

P. O. Address 3505 Oak

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.