THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

43109

FILED DEC 27 1956

STATE FILE NUMBER 11246

Registration District No. 318 Primary Registration District No. 1003 Registrar's 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 Saint Louis — Inside Limits Yes X No ☐	c. CITY OR TOWN Saint Louis — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 5325 Claxton Ave., — Length of stay in lb 30 Yrs. 20790	d. STREET ADDRESS (If outside, give location) 5325 Claxton Avenue, — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: OPAL	Middle: A.	Last: GREIMANN	4. DATE OF DEATH Month Day Year: Dec. 7th, 1956
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Nov. 15th, 1897	9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (City and state or country): Belleville, Illinois	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: August Buffard		14. MOTHER'S MAIDEN NAME: Louise Werner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO.: Unknown	17. INFORMANT Address: William F. Greimann, 5325 Claxton Ave., 20		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6 months

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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): 420.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 June 16, 1956 to Dec 7, 1956 and last saw her/him alive on Dec 5, 1956. Death occurred at 8:30A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): O E Tyffel MD

22b. ADDRESS: 4222 N. Grand

22c. DATE SIGNED: 12-8-56

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 12/10/56	23c. NAME OF CEMETERY OR CREMATORY: Zion Cemetery	23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri
24. FUNERAL DIRECTOR ADDRESS: CALVIN F. FEUTZ, 4828 Natural Bridge Blvd. FUNERAL HOME, INC., St. Louis, 15, Mo.		25. DATE RECD. BY LOCAL REG.: DEC 10 1956	26. REGISTRAR'S SIGNATURE: Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

File in City

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John A. Mlina

Licensed Embalmer No. 41

P. O. Address St. Lou

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.