

Health, Welfare, Public Service

300 1-56

Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2656

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 532

| | | | | | | | |
|--|---------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2035 Alfred Ave. | | | Length of stay in 1b | d. STREET ADDRESS 2035 Alfred Ave. | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last OTTILIA DECKMEYER | | | | 4. DATE OF DEATH Month Day Year Jan. 16 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 4, 1867 | | 9. AGE (In years last birthday) 89 | IF UNDER 1 YEAR Months Days 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 | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Bauer | | | | 14. MOTHER'S MAIDEN NAME Gottlieb Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Fred A. Deckmeyer 2035 Alfred 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>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Generalized Arteriosclerosis</i> 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>420.0</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> <i>2 years</i> |
| 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.) | | | | |
| 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 <i>1955</i> to <i>Jan 16, 1957</i> and last saw <i>her</i> alive on <i>Jan 16, 1957</i> Death occurred at <i>3:50 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Joyce P. Kestelb Jr M.D.</i> | | | | 22b. ADDRESS <i>4952 Monyland</i> | | 22c. DATE SIGNED <i>17 Jan 57</i> | |
| 23a. BURIAL, CREMATION, REBURYAL (Specify) <i>Burial</i> | | 23b. DATE <i>Jan. 19, 1957</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i> | | 23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i> | | |
| 24. FUNERAL DIRECTOR ADDRESS <i>Kriegshauser 4228 S. Kingshighway</i> | | | | 25. DATE RECD. BY LOCAL REG. <i>JAN 17 '57</i> | | 26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i> | |

(Licensed Embalmer's Statement on Reverse Side)

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
Signature of Student Embalmer

Signed *Richard W. Storrs*

Licensed Embalmer No. *40*

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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..