

Health, Welfare
Public Service

300
7-56

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 26 1957

6278

STATE FILE NUMBER

1343

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 <u>Missouri</u> b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>ST. LOUIS</u> | | Inside Limits/ Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DEACONESS Hosp.</u> | | Length of stay in <u>1b</u> | d. STREET ADDRESS <u>3154 PENNSYLVANIA</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>EMMA HEINRITZ</u> | | | 4. DATE OF DEATH <u>FEB. 8 1957</u> | 5. SEX <u>FEMALE</u> | |
| 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>DEC. 22 1874</u> | 9. AGE (In years last birthday) <u>82</u> | IF UNDER 1 YEAR Months | IF UNDER 24 MRS. Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>ST. LOUIS Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>GEORGE HEINRITZ</u> | | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH SUESS</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT Address <u>CATHERINE MUELLER 329 SIDNEY</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chy Myocarditis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u> | | | | | 1 1/2 |
| DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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 <u>2/1/1956</u> to <u>2/7/57</u> and last saw her alive on <u>2/7/57</u> Death occurred at <u>7:35 A. m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>Hubert P. Smith MD</u> | | 22b. ADDRESS <u>5203 Chaffee</u> | 22c. DATE SIGNED <u>2/9/57</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL FEB. 11 1957</u> | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL CHURCHYARD</u> | 23d. LOCATION (City, town, or county) <u>ST. LOUIS Mo.</u> | 23e. (State) | |
| 24. FUNERAL DIRECTOR <u>Thomas Kutie 2906 Gravois</u> | | 25. DATE RECD. BY LOCAL REG. <u>FEB 11 '57</u> | 26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> | | |

(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 *James C. Will*
Licensed Embalmer No. 43

P. O. Address 2906
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**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.**