

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 18 1957

318

1003

10147

STATE FILE NUMBER

1797

Registration District No. .... Primary Registration District No. .... Registrar's No. ....

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, 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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>01 3225 N. Florissant</b>		Length of stay in lb <b>4 yrs. 2</b>		d. STREET ADDRESS <b>3225 N. Florissant</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Michael Deits</b>				4. DATE OF DEATH <b>Feb. 19, 1957</b>			
5. SEX <b>Male 0</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 20, 1874</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		100. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Waterloo, Ill. /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Matthew Deits</b>				14. MOTHER'S MAIDEN NAME <b>Kudegundies Streckel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Cecelia Schneider, 7340 Burrwood</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>? ? - ?</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b)	
						DUE TO (c) <b>None</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
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.)					
<b>None</b>							
20c. TIME OF INJURY Hour Month, Day, Year <b>None</b>							
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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	
<b>None</b>							
21. I attended the deceased from <b>10 1955</b> to <b>Feb 19, 1957</b> and last saw him alive on <b>Feb 19, 1957</b> . Death occurred at <b>10</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Ernest H. Hoppe MD</b>				22b. ADDRESS <b>2435 N. Grand Blvd</b>		22c. DATE SIGNED <b>2-20-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2-20-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Todd Mill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pinckneyville, Ill.</b>	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 21 '57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	

mgs

MISSOURI

STATE OF MISSOURI

DEPARTMENT OF HEALTH

BUREAU OF PUBLIC HEALTH

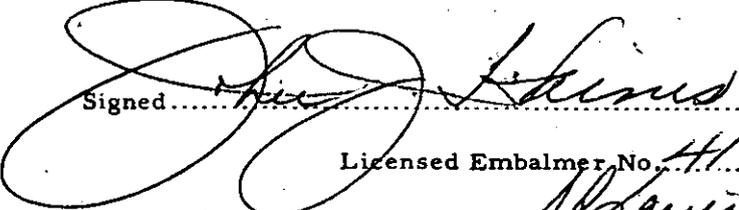
COLUMBIA, MISSOURI

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**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.....   
 Licensed Embalmer No. 410  
 P. O. Address St. Louis

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

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