

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10389

STATE FILE NUMBER

FILED MAR 29 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2094

Health, Welfare Public Service

300 1-56

Disease, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All deaths 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 No St. Louis COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Clayton		4452 0	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital			Length of stay in lb 9 days	d. STREET ADDRESS #31 Brentmoor Pk		27 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Luella Kaufmann Hecker				4. DATE OF DEATH Month Day Year Feb. 28, 1957			
5. SEX F / W	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 4, 1885	9. AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo. 0		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Kaufmann				14. MOTHER'S MAIDEN NAME Bertha Hoch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If specify war or dates of service) No None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Walter C. Hecker 31 Brentmoor Pk.			
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>Coronary thrombosis</u> <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>generalized arterio-sclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Rheumatoid arthritis</u> (Rheumatoid arthritis) <u>Feb. 1</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>Sept. 1936</u> to <u>Feb. 28-1957</u> and last saw <u>him</u> alive on <u>Feb. 28-1957</u> . Death occurred at <u>11:30 p. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE H. G. Newman <u>H. G. Newman M.D.</u> (Degree or title)				22b. ADDRESS <u>3720 Washington</u>		22c. DATE SIGNED <u>3-1-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE March 2, 1957	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)	
24. FUNERAL DIRECTOR <u>W. Anderson Sons, 6075 Delmar</u>			25. DATE RECD. BY LOCAL REG. MAR 2 '57		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		

1-5

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 *Jos. E. McCulloch*

Licensed Embalmer No. *296*

P. O. Address *6175 St*

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.