

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18785

STATE FILE NUMBER

4487

FILED MAY 27 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

Health,
Welfare
Public
Service

300
7-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms writ 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				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <i>St. Louis</i>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		a. STATE <i>Missouri</i>		b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Mo. Pacific Hospital</i>		Length of stay in lb <i>26 7/8</i>		c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
First <i>Joseph</i>		Middle <i>Henry</i>		Last <i>Helming</i>		4. DATE OF DEATH	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-27-1878</i>	
9. AGE (In years last birthday) <i>79</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Switchman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Switchman</i>		11. BIRTHPLACE (City and state or country) <i>St. Louis, Missouri</i>	
10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Switchman</i>		10d. KIND OF BUSINESS OR INDUSTRY <i>Switchman</i>		11. BIRTHPLACE (City and state or country) <i>St. Louis, Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Helming</i>				14. MOTHER'S MAIDEN NAME <i>Mathilda Greenrod</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Joseph L. Helming, Box 243, Dunlap, Kansas</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH <i>32 days</i>	
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>							
DUE TO (b) <i>Arterio-sclerosis</i>							
DUE TO (c) _____						<i>33 2x</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20e. CITY, TOWN, OR LOCATION	
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>April 7-57</i> to <i>May 9-57</i> and last saw ^{her} him alive on <i>May 9-57</i>							
Death occurred at <i>6:15 p. m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Benjamin H. Charles M.D.</i>				22b. ADDRESS <i>Res. Pac. Hospital - St. Louis</i>		22c. DATE SIGNED <i>May 10, 1957</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<i>Removal-Cremation 5/11/57</i>		<i>5/11/57</i>		<i>Oak Grove Crematory</i>		<i>St. Louis County, Missouri</i>	
24. FUNERAL DIRECTOR <i>CALVIN F. PEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, INC., St. Louis, 15, Mo.</i>				25. DATE, REC'D. BY LOCAL REG. <i>MAY 11 '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 *John A. Mena*.....

Licensed Embalmer No. *41*

P. O. Address *St. Louis*

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.