

Health,
Welfare
Public
Service

FILED JUL 26 1957

STANDARD CERTIFICATE OF DEATH

26538
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **6635**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI 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 checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3512 A Osage		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1517 3512 A Osage		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Josephine			4. DATE OF DEATH Month 7 - Day 14 - Year 1957		
First Josephine	Middle R.	Last Schleifstein	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 10-18-1884	9. AGE (In years last birthday) 72	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. Jacobs Illinois	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Anton Bertel			14. MOTHER'S MAIDEN NAME ANNA Hilker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address MRS. Dorothy Sick 3512 A Osage		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arterial heart disease					INTERVAL BETWEEN ONSET AND DEATH 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					420.0
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 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		20g. COUNTY STATE
21. I attended the deceased from Sept 1955 , to July 14, 1957 and last saw her ^{her} _{him} alive on 7-13-57 Death occurred at 5:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Albert J. Grude M.D. (Degree or title)			22b. ADDRESS 3606 Gravois		22c. DATE SIGNED 7-16-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-17-1957	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR Wingbermuehle		ADDRESS 3819 So. Grand	25. DATE RECD. BY LOCAL REG. JUL 16 57	26. REGISTRAR'S SIGNATURE Carl Smith M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *Leo Klingbermuehle*.....

Licensed Embalmer No. *46*.....

P. O. Address *A. Home*.....

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.