

FILED OCT 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37517
STATE FILE NUMBER
1003
10002

Registration District No. 318 Primary Registration District No. 1003 Registrar No. 10002

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 <i>St. Louis, Mo.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i>		Length of stay in 1b <i>7 Days</i>	d. STREET ADDRESS <i>6225 Arsenal St</i>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Lena</i> Middle Last <i>Halter</i>			4. DATE OF DEATH Month <i>10</i> Day <i>24</i> Year <i>57</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 18, 1884</i>	9. AGE (In years last birthday) <i>73</i> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Kept House</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House Wife</i>	11. BIRTHPLACE (City and state or country) <i>Hamburg, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>US.</i>
13. FATHER'S NAME <i>Jacob Stehr</i>			14. MOTHER'S MAIDEN NAME <i>Mary Westrich</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Mrs. Cleola Hein 6225 Arsenal St</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO (b) <i>ARTERIOSCLEROSIS</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <i>?</i> <i>?</i> <i>.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>ATELECTASIS BOTH LOWER LOBES PLEURAL EFFUSION</i>					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 a. m. p. m.					
20d. INJURY OCCURRED WHILE AT <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>OCT 10 1955</i> to <i>OCT 24 1957</i> and last saw her alive on <i>10/24/57</i> Death occurred at <i>4:30 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Raymond V. Mueller MD</i>			22b. ADDRESS <i>4401 Houghton</i>		22c. DATE SIGNED <i>10/25/57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>10-28-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St Marys Cemetary</i>		23d. LOCATION (City, town, or county) (State) <i>Cape Girardeau, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Weick Bros 2201 S. Grand Blvd.</i>		25. DATE RECD. BY LOCAL REG. <i>OCT 25 57</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	

Dr. Henschel
4401 Hampton

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 *Harvey Kahle*
Licensed Embalmer No. *4596*

P. O. Address *Flourissant*

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.