

FILED DEC 10 1957

STATE FILE NUMBER  
**10624**

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

S. 300  
ev. 1-57

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>CITY-HOSPITAL #1</b>		Length of stay in lb <b>LIFE.</b>		d. STREET ADDRESS (If outside, give location) <b>1516-NO. MARKET-ST.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <b>ELIZABETH FELDEWERT</b>				4. DATE OF DEATH Month Day Year <b>NOV. 6TH 1957</b>			
5. SEX <b>FEMALE</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>NOV. 8TH 1869</b>		9. AGE (In years last birthday) <b>87 YRS.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT-HOME</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS - MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>HENRY-FELDEWERT</b>			13b. MOTHER'S MAIDEN NAME <b>MARGARET-TEGETHOFF</b>			14. NAME OF HUSBAND OR WIFE <b>&lt; SINGLE &gt;</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>ANNA-SCHMITZ = 5703-HELEN-AV.</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>Mesenteric Thrombosis;</b> DUE TO (b) <b>Arterio Sclerosis;</b> DUE TO (c) <b>Fracture of Hip, (right)</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in PART I or PART II if from a fall) <b>Injured at Mother's Home Hospital November 1, 1957.</b>				
20c. TIME OF INJURY Hour a.m. p.m. <b>11 1 57</b>			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.) <b>25 Hosp</b>		
20f. CITY, TOWN, OR LOCATION <b>St Louis Mo</b>			COUNTY <b>800</b>		STATE		
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ <b>9:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Delores J. York</b> (Degree or title)				22b. ADDRESS <b>1300 Elm</b>		22c. DATE SIGNED <b>11/6/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>NOV. 9TH 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY-CEMETERY</b>			23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO.</b>	
24. FUNERAL DIRECTOR <b>Brockland Und. Co</b>				ADDRESS <b>1827-HOGAN-ST</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 8 '57</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith MD</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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.

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 *Robert M. Murray* .....

Licensed Embalmer No. *3749* .....

P. O. Address *St. Louis, Mo* .....

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.