

Health,  
& Welfare  
Public  
Service

S. 300  
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will 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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 21 1957

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

42260

STATE FILE NUMBER

10861

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony Hosp.</b>			Length of stay in lb <b>22</b>		d. STREET ADDRESS <b>3821 Wyoming</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Estelle</b> Middle <b>L.</b> Last <b>Lewitz</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>1957</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 13, 1884</b>		9. AGE (In years last birthday) <b>73</b>		IF UNDER 1 YEAR Month <b>3</b> Days <b>28</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George H. Laumann</b>				14. MOTHER'S MAIDEN NAME <b>Louisa Fricker</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Carl Lewitz</b> Address <b>3821 Wyoming</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>Cerebral Thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <b>Chronic Myocarditis</b>				<b>3 yrs.</b>		
			DUE TO (c) <b>Hypertension</b>				<b>4 yrs.</b>		
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.) <b>443x</b>						
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 <b>10/29/57</b> to <b>11/11/57</b> and last saw her alive on <b>11/11/57</b> Death occurred at <b>7:10</b> P. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Benjamin [Signature]</i> (Degree or title)				22b. ADDRESS <b>7430 Virginia Avenue</b>			22c. DATE SIGNED <b>11/12/57</b>		
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov. 14, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>			
24. FUNERAL DIRECTOR <b>Schumacher's 3013 Meramec St.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>NOV 14 '57</b>		26. REGISTRAR'S SIGNATURE <i>Carl Smith</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 *Jack Haupt*.....

Licensed Embalmer No. *474*

P. O. Address *St. Louis*

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.