

Health,
Welfare
Public
Service

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-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Part 18. All diseases in Part 1 must be causally related.

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED JAN 27 1958

Registration District No. 317

Primary Registration District No. 546

Registrar's No. 198

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Overland</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Overland 423X</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9620 W. Milton</u>		Length of stay in 1b <u>15 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>9620 W. Milton</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H</u> Last <u>Korte</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 1, 1901</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper ruler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Korte Ruling Co.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Charles H. Korte</u>		13b. MOTHER'S MAIDEN NAME <u>Bertha Mertens</u>	
14. NAME OF HUSBAND OR WIFE <u>Ethel Stadtmiller Korte</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>492-05-7940</u>	
17. INFORMANT <u>Ethel Korte</u>		Address <u>9620 W. Milton</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Acute Coronary Occlusion</u> DUE TO (c) <u>4201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Proximal Ulcer</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>		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 <u>11:45 AM</u> Month <u>10</u> Day <u>12</u> Year <u>57</u>		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 <u>Overland</u>		COUNTY <u>Mo.</u> STATE <u>Mo.</u>	
21. I attended the deceased from Death occurred at <u>11:45 AM</u> to <u>Present</u> and last saw him alive on <u>1-20-58</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>J. H. Clark D.O.</u> (Deputy or title) <u>2</u>		22b. ADDRESS <u>3301 Ashby</u>	
22c. DATE SIGNED <u>1-20-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Jan 23, 1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SS Peter & Paul Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis City Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Ortmann F. Home</u>		ADDRESS <u>0222 Lackland Overland 14, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 21, 1958</u>	
26. REGISTRAR'S SIGNATURE <u>Herbert R. Daniels MD</u>		(Licensed Embalmer)		Statement on Reverse Side	

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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 *Al. Q. Ostmann*

Licensed Embalmer No. *3478*

P. O. Address

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.