

Health,
Welfare
Public
Service

FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008244
STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 547 Registrar's No. 469

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Richmond Affs</u>		Inside Limits No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>40002 CREVE COEUR MO</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY'S</u>		Length of stay in 1b <u>4 days.</u>	d. STREET ADDRESS (If outside, give location) <u>Rural Route</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>G.</u> Last <u>TIMMERMAN</u>			4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 5 - 1891</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>Breeze ill</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Theobald Timmerman</u>		13b. MOTHER'S MAIDEN NAME <u>MARY Bixschlag</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>None</u>	17. INFORMANT Address <u>Geo. J. Wingbermuehle 3819 S. Grand</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>Cerebral vascular Accident</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u>					<u>15 years</u>
DUE TO (c) <u>331X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Severe Hyponatremia</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. DESCRIPTION OF INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <u>1</u> a.m. <u>00</u> p.m. <u>00</u>					
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 <u>Feb 9, 1958</u> to <u>Feb 12, 1958</u> and last saw him alive on <u>Feb 17, 1958</u> Death occurred at <u>1st ave</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Walter H. Austin MD</u>			22b. ADDRESS <u>634 N. Grand Blvd</u>		22c. DATE SIGNED <u>2-14-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>2-15-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. DOMINIC'S Cem.</u>	23d. LOCATION (City, town, or county) <u>Breeze</u>		(State) <u>Illinois</u>
24. FUNERAL DIRECTOR ADDRESS <u>Wingbermuehle 3819 S. Grand</u>		25. DATE RECD. BY LOCAL REG. <u>2-14-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

80

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 *Geo. J. Ringermuehle, Jr.*

Licensed Embalmer No. *4611*
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.