

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015914
STATE FILE NUMBER

FILED APR 18 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3720

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>01 2656 PENNSYLVANIA</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>1179 2656 PENNSYLVANIA</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSE MAY HERTEL</u> | | | 4. DATE OF DEATH Month Day Year <u>April 1 1958</u> |
| 5. SEX <u>FEMALE</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>JULY 3 1893</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 9. AGE (In years last birthday) <u>64</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 11. BIRTHPLACE (City and state or country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>CYRUS SPARKS</u> | | 13b. MOTHER'S MAIDEN NAME <u>HATTIE GREEN</u> | 14. NAME OF HUSBAND OR WIFE <u>CHRISTIAN G. HERTEL</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT Address <u>CHRISTIAN HERTEL 2656 PENNSYLVANIA</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>CORONARY THROMBOSIS</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>ONE HOUR</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CORONARY ARTERIOSCLEROTIC HEART DISEASE</u> | | | <u>THREE YEARS</u> |
| DUE TO (c) <u>HEALED MYOCARDIAL INFARCTION</u> | | | <u>TWO YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.1</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 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 <u>JAN. 22 1955</u> to <u>APR. 1, 1958</u> and last saw her ^{her} alive on <u>MARCH 24, 1958</u> Death occurred at <u>8:10 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Anna Carver, MD</u> (Degree or title) | | 22b. ADDRESS <u>4401 HAMPTON, ST. LOUIS 9, MO</u> | 22c. DATE SIGNED <u>4-2-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>Apr. 4 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LAKWOOD PARK</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u> |
| 24. FUNERAL DIRECTOR <u>Thomas Kuttis 2906 Leavis</u> | 25. DATE RECD. BY LOCAL REG. <u>APR 2 '58</u> | 26. REGISTRAR'S SIGNATURE <u>Paul Smith MD</u> | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

7-1183

4401
New York State

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 *Leo J. Biddle*

Licensed Embalmer No. *3989*

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.