

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016000

STATE FILE NUMBER 1903

FILED MAY 14 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300
1-57

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. | | c. CITY OR TOWN St. Louis | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1. | | d. STREET ADDRESS (If outside, give location) 1707a So. 8th St. | |
| Length of stay in lb 3 days | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) EMMA KARHERINE JOST | | | 4. DATE OF DEATH Month MAY Day 6 Year 1958 | | |
| First Middle Last | | | | | |

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| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 28, 1893 | 9. AGE (In years last birthday) 65 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse | 10b. KIND OF BUSINESS OR INDUSTRY City Hospital | 11. BIRTHPLACE (City and state or country) Stanton, Ill. | 12. CITIZEN OF WHAT COUNTRY? U.S. |
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| 13a. FATHER'S NAME Albert Eckhoff Lebbe Janssen | 13b. MOTHER'S MAIDEN NAME Caroline Ida Unknown Altenvolk | 14. NAME OF HUSBAND OR WIFE Henry Jost |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. 499-28-4155 | 17. INFORMANT Address Mrs. Edith Cameron, 1133 Lawn Ave. |
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| MEDICAL CERTIFICATION Corrected by affidavit 6/13/58 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH |
| | DUE TO (b) ? Cerebrovascular Accident | | |
| | DUE TO (c) | | |
| 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"/> |

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| 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.) |
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| 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 |
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| 21. I attended the deceased from 5/3/58 to 5/6/58 and last saw her alive on 5/6/58 Death occurred at 10:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE Aaron M. Bernstein M.D. | 22b. ADDRESS 1515 LAFAYETTE AVE. | 22c. DATE SIGNED 5/8/58. |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 5-8-58 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. |
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| 24. FUNERAL DIRECTOR ADDRESS Shepard Funeral Home, 1167 Hamilton Ave. | 25. DATE RECD. BY LOCAL REG. MAY 8 58 | 26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. |
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All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

James O. Surley
James O. Surley
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 *James O. Surley*
Licensed Embalmer No. *4979*

P.O. Address *So. Laurel, Md.*

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.