

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016081

STATE FILE NUMBER

FILED APR 23 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3943**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		a. STATE Illinois b. COUNTY ST CLAIR		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Lukes Hospital				Length of stay in 1b 2 Mo 3 day		d. STREET ADDRESS (If outside, give location) 815 Sparks		
3. NAME OF DECEASED (Type or print) First Dorothy Middle Marie Last Keirer				4. DATE OF DEATH Month April Day 8 Year 1958				
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 May 17 1926		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Parma Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A		
13. FATHER'S NAME Marion Thomas Allen				14. MOTHER'S MAIDEN NAME Virginia Belle Montgomery				
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. No one		17. INFORMANT Address W. D. Keirer - Maplewood Pk - Ill				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis							INTERVAL BETWEEN ONSET AND DEATH 7 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							592x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 8:00 Month April Day 11 Year 1958 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 1936 to 4/8/58 and last saw her alive on 4/8/58 Death occurred at 8:00 am m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Type or print) W Baumgarten Jr - MD.				22b. ADDRESS 3720 Washington Ave, St. Louis		22c. DATE SIGNED 4/9/58		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-11-58		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial		23d. LOCATION (City, town, or county) (State) Belleville Illinois		
24. EMBALMER'S DIRECTOR W. H. ...			ADDRESS St. Louis, Ill		25. DATE RECD. BY LOCAL REG. APR 9 '58		26. REGISTRAR'S SIGNATURE Carl Smith MD	

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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 em
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
E. Schaefer

Licensed Embalmer No.. 216

P. O. Address *E. Schaefer*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.