

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023663  
STATE FILE NUMBER

FILED JUN 27 1958

318

1003

Registrar's No. 6011

Registration District No. \_\_\_\_\_ Primary Registration District 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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Incarinate Word Hosp</b>		Length of stay in lb <b>8 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>4484 West Pine</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print). First <b>JACOB (JAKOB)</b> Middle <b>RENNER</b> Last			4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1958</b>		
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5. SEX <b>male 0</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 6, 1892</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 24 HRS. Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>attendant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>animal care</b>	11. BIRTHPLACE (City and state or country) <b>Austria-Hungary 4</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Philip Renner</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Mannweiler</b>	14. NAME OF HUSBAND OR WIFE <b>Katherine Wild Renner</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>199-34-5175</b>	17. INFORMANT Address <b>Katherine Renner, 4484 West Pine Blvd</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 2 days</b> <b>2 wks.</b>
DUE TO (b) <b>Hypertension</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>332x</b>		

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 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 <b>5-8-58</b> to <b>6-9-58</b> and last saw him <sup>alive</sup> on <b>6-9-58</b> Death occurred at <b>10:45 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>A. Dwarshorn M.D.</b>	22b. ADDRESS <b>1657 So Grand</b>	22c. DATE SIGNED <b>6/10/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>June 12, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave</b>	25. DATE RECD. BY LOCAL REG. <b>JUN 11 58</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Dr. S. Dworkin  
1657 S. Grand  
12 - 3 PM

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  \_\_\_\_\_

Licensed Embalmer No. 4520  
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.