

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024034
STATE FILE NUMBER

FILED JUL 14 1958 Registration District No. 317 Primary Registration District No. 545 Registrar's No. 1809

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maplewood		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3135 Cherry Ave		d. STREET ADDRESS (If outside, give location) 3628 Dover	
3. NAME OF DECEASED (Type or print) First Ida Middle C Last Kreienheder		4. DATE OF DEATH Month July Day 6 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 12, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or country) High Ridge, Mo.
13a. FATHER'S NAME Herman Hollman		13b. MOTHER'S MAIDEN NAME Augusta Baumbach	14. NAME OF HUSBAND OR WIFE deceased
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. 492-24-5963	17. INFORMANT Address Walter Kreienheder 3628a Dover
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion			INTERVAL BETWEEN ONSET AND DEATH Sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arterio-sclerotic heart disease			4 years
DUE TO (c) 4700			
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"/>
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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 Oct. 25, 54 to July 6, 1958 and last saw her alive on June 6, 58 Death occurred at 100 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Arthur B. Ray M.D.		22b. ADDRESS 3720 Washington Ave	22c. DATE SIGNED 7-7-58
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 7/9/1958	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) (State) Affton, Mo.
24. FUNERAL DIRECTOR ADDRESS J L Ziegenhein & Sons 7027 Gravidis		25. DATE RECD. BY LOCAL REG. 7-7-58	26. REGISTRAR'S SIGNATURE Herbert P. Danke M.D.

All diseases in Part I must be causally related.

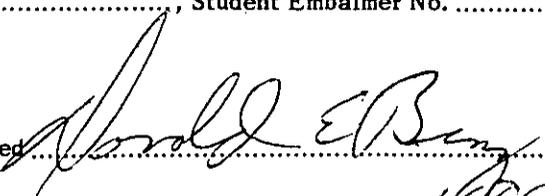
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

P. O. Address

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.