

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027839

STATE FILE NUMBER

FILED JUL 24 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1875

S. 300

1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				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>Manchester</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input 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>Pine Crest Nur- ing Home</b>		Length of stay in 1b <b>4 mos. 24</b>		d. STREET ADDRESS (If outside, give location) <b>543 Baden Ave.,</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Theresa</b> Middle Last <b>Randolt</b>				4. DATE OF DEATH Month <b>July</b> Day <b>14</b> , Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 19th, 1871</b>		9. AGE (In years, last birthday) <b>86</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Theodore Casper</b>		13b. MOTHER'S MAIDEN NAME <b>not known</b>		14. NAME OF HUSBAND OR WIFE <b>Killian Randolt</b>			
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>498-20-9487</b>		17. INFORMANT Address <b>Pine Crest Nursing Home, Manchester</b>			
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>Acute Myocardial Insufficiency</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cardiac Dilatation (chronic)</b> DUE TO (c) <b>Chronic Myocarditis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Don't know</b> <b>Don't know</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>452.2</b>						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 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 <b>May 2, 1958</b> to <b>July 14, '58</b> and last saw her alive on <b>July 14, '58</b> Death occurred at <b>10:40 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Ralph W. Lafey, M.D.</b>				22b. ADDRESS <b>Manchester Rd. Box 122, Manchester, Mo.</b>		22c. DATE SIGNED <b>7-14-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>7/17/58</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>				25. DATE RECD. BY LOCAL REG. <b>7-15-58</b>		26. REGISTRAR'S SIGNATURE <b>Herbert R. Donk, M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Product

Serial No.

Manufacturer's Name

City

State

County

Office No.

Telephone No.

Signature of Embalmer

Date

Time of Day

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 ..... [Handwritten Signature]

Licensed Embalmer No. 365

P. O. Address St. Lewis

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.