Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-031358
STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2134

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Lemay — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 01 9353 S. Broadway — Length of stay in 1b 2½ YRS. 2029

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 5229 Blow — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Sophia Middle Last Helke

4. DATE OF DEATH Month August Day 13 Year 1958

5. SEX female 1
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH May 4, 1880
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
10b. KIND OF BUSINESS OR INDUSTRY housewife
11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Fischer
13b. MOTHER'S MAIDEN NAME Mary Seiz
14. NAME OF HUSBAND OR WIFE Arthur (deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. UNK.
17. INFORMANT Edward O'Rourke Address 5229 Blow

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 20 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chronic Myocarditis — 8 mos.
DUE TO (c) Chronic Nephritis — 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 592X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 WORK ☐ NOT WHILE AT WORK ☐
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 March 3 1958, to Aug 13, 1958 and last saw her/him alive on Aug 13, 1958
Death occurred at 8:25 p.m. 8-13-58 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John C. Crawford M.D. 2
22b. ADDRESS 9612 S. Broadway
22c. DATE SIGNED 8-13-58

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 8/16/1958
23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

24. FUNERAL DIRECTOR ADDRESS J L Ziegenhein & Sons 7027 Gravois
25. DATE RECD. BY LOCAL REG. 8-15-58
26. REGISTRAR'S SIGNATURE Herbert R. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.