

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031387
STATE FILE NUMBER

FILED SEP 12 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2237

| | | | | | |
|--|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Frontenac | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Frontenac 4410 8 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 15 Frontenac | | Length of stay in 1b 3 yrs. | d. STREET ADDRESS 15. Frontenac | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last HERMAN RINDSKOPF | | | 4. DATE OF DEATH Month Day Year Aug. 26, 1958 | | |
| 5. SEX Male <input checked="" type="checkbox"/> | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1865 Nov. 24, 1865 | 9. AGE (In years last birthday) 94 92 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Director | | 10b. KIND OF BUSINESS OR INDUSTRY Funeral | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 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. 496-36-2144 | 17. INFORMANT Address Clarence B. Roth-#3 Country Fair Lane | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Liver | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Metastasis Kidney | | | | | 1 Year |
| DUE TO (c) 156.1 | | | | | @ Weeks |
| 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 Month, Day, Year a. m. 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 1948 to Aug. 26, 58 and last saw her alive on Aug 26, 58 Death occurred at 8 PM m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Doris J. Lewis M.D. | | | 22b. ADDRESS 440 N Taylor ave | 22c. DATE SIGNED 8/27/58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 8/28/58 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri | | |
| 24. FUNERAL DIRECTOR Herman Rindskopf, Inc. 5216 Delmar | | 25. DATE RECD. BY LOCAL REG. 8-27-58 | 26. REGISTRAR'S SIGNATURE Herbert R. Bomke M.D. | | |

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Completed by
affidavit 10/4/58
DCL

DR

SEP 24 1958

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. 388

P. O. Address.....

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.

OCT 17 1958