

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037606
STATE FILE NUMBER

FILED OCT 17 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 9577

300
-57

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1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Memorial Home 2609 South Grand			Length of stay in lb 2 1/2	d. STREET ADDRESS 2609 South Grand Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADELAIDE Middle NMI Last BIEDERMAN				4. DATE OF DEATH October 5, 1958 Month Day Year			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 22, 1874		9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Albert Biederman			13b. MOTHER'S MAIDEN NAME Adeline Dietmeier		14. NAME OF HUSBAND OR WIFE None		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN			16. SOCIAL SECURITY NO. 493-07-8530A	17. INFORMANT Address Mbs Memorial Home 2609 South Grand Ave. St. Louis			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerotic vascular disease</u>						many years	
DUE TO (c) <u>331x</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)						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 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 <u>July 1 - 58</u> to <u>Sept. 30 - 58</u> and last saw her/him alive on <u>Sept. 30 - 58</u> Death occurred at <u>7 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Frances R. Ritchie</u> (Degree or title)				22b. ADDRESS M.D. 5233 Waterman Avenue		22c. DATE SIGNED 10/6/1958	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/7/1958	23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri		
24. FUNERAL DIRECTOR C.R. Lupton and Sons 7233 Delmar Blv'd.				25. DATE RECD. BY LOCAL REG. OCT 6 '58		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> mjb	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

(C I T Y)

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*
P. O. Address *St. Louis, Mo*

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.