

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038500

STATE FILE NUMBER

FILED OCT 20 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2629

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Lemay, St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LEMAY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis (29)</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>5700 Bluff Rd.</b>			Length of stay in lb <b>22 Yrs.</b>		d. STREET ADDRESS <b>5700 Bluff Rd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>FRIEDA F. MERZ</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>10th</b> Year <b>1958</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 17, 1910</b>		9. AGE (In years last birthday) <b>48</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Perry Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Benjamin Ponder</b>			13b. MOTHER'S MAIDEN NAME <b>Ida Schott</b>			14. NAME OF HUSBAND OR WIFE <b>Anthony A. Merz</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>None</b>		17. INFORMANT <b>Anthony A. Merz</b>			Address <b>5700 Bluff Rd. (29)</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>ac. dilatation of heart</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>generalized La metastasis</b>		DUE TO (c) <b>Ca of ovary</b>		175.0		<b>6 months</b>	
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.									
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 <b>5-1-58</b> to <b>10-10-58</b> and last saw her alive on <b>10-10-58</b> Death occurred at <b>2:20 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Ernie W. Reubens M.D.</i>				22b. ADDRESS <b>752 Lemay Ferry 14</b>		22c. DATE SIGNED <b>10-13-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 13, 1958.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis (25)</b>		STATE <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>Fendler Und.Co. 7420 Michigan (11)</b>				25. DATE RECD. BY LOCAL REG. <b>10-13-58</b>		26. REGISTRAR'S SIGNATURE <i>Herbert P. Donke M.D.</i>			

(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

MEDICAL CERTIFICATION

Dr. E. D. Greenleaf

75 Y Lenny Ferry Rd

Office Fl 3 - 2224

Home Fl 2 - 8275

14 to 2

Mon.

**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 *W. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address *7420 Mich*

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.