

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041229

STATE FILE NUMBER

FILED DEC 9 1958 Registration District No.

318

Primary Registration District No.

1003

Registrar's No. 11372

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
18 FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Park Lane Hospital</u>		Length of stay in lb <u>6 weeks</u>	
d. STREET ADDRESS <u>3403 McKean Ave.</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Adele</u> Middle <u>Ampleman</u> Last <u>Ampleman</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1872</u>
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Charles Vincent</u>	
13b. MOTHER'S MAIDEN NAME <u>Marie Bievenue</u>		14. NAME OF HUSBAND OR WIFE <u>Leon Ampleman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>William Kamlade</u> Address <u>10456 Seaton Dr.</u>
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>Acute Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Since 10/17/58</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>420.1</u>			
DUE TO (c) <u></u>			
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u></u>	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>			
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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u> STATE <u></u>
21. I attended the deceased from <u>10/15/58</u> to <u>11/24/58</u> and last saw her/him alive on <u>11/24/58</u> Death occurred at <u>11/24/58</u> <u>9:30 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Alonza Mallett M.D.</u> (Degree or title)		22b. ADDRESS <u>105 University Club Bldg.</u>	22c. DATE SIGNED <u>11/25/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/28/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>
24. FUNERAL DIRECTOR <u>Gebken Sons</u> ADDRESS <u>2630 Gravois Av.</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 25 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Herbert J. Gan Jr.*

Licensed Embalmer No. *4820*

P. O. Address *Richmond 29*

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.