

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042093

STATE FILE NUMBER

10966

Registration District No.

318

Primary Registration District No.

1003

Registration District No.

FILED DEC 1 1958

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O/ 5145 Lindell, Blvd.		d. STREET ADDRESS (If outside, give location) #1210 5145 Lindell Blvd.	
3. NAME OF DECEASED (Type or print) First Middle Last Ida K. Petring		4. DATE OF DEATH Month Day Year November 12, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1895
9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Samuel Alonzo Kilpatrick		13b. MOTHER'S MAIDEN NAME Martha Greenhalgh	
14. NAME OF HUSBAND OR WIFE Robert O. Petring		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No. Nil.	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Robert O. Petring, 5145 Lindell, Blvd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic myocarditis DUE TO (c) 422.2			INTERVAL BETWEEN ONSET AND DEATH
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. Month, Day, Year		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 December 1, 1955 to November 12, 1958 and last saw her alive on November 11, 1958 Death occurred at 9:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Thomas F. Summers, M.D.		22b. ADDRESS 3857 Lindell, St. Louis 8	
22c. DATE SIGNED 11-12-58		23a. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum	
23b. DATE 11-15-58		23c. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. NOV 14 58	
26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. S.P.			

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 *W. W. Wilkinon* .....

Licensed Embalmer No. *3575* .....  
P. O. Address *4 Louis* .....

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.