

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046781

STATE FILE NUMBER

FILED DEC 22 1958

Registration District No.

317

Primary Registration District No.

500

Registrar's No.

3286

300 4  
1-57

1. PLACE OF DEATH a. COUNTY <b>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>Creve Coeur</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Creve Coeur</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>Evergreen Nursing Home, yrs.</b>		Length of stay in lb <b>4 yrs.</b>	d. STREET ADDRESS <b>Olive Street Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>OLGA</b> Middle <b>nmn</b> Last <b>HEROLD</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>14,</b> Year <b>1958</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>about 81 yrs</b>		9. AGE (In years last birthday) <b>about 81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House work</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Ferdinand Herold</b>		13b. MOTHER'S MAIDEN NAME <b>Sophia unknown</b>		14. NAME OF HUSBAND OR WIFE <b>None</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>unknown</b>	17. INFORMANT Address <b>Harold Meurer, Dickinson, Texas</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>Thrombosis Cerebral vessel</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
DUE TO (b) <b>Generalized arteriosclerosis</b>					<b>?</b>
DUE TO (c) <b>332X</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Previous thrombi in cerebral vessels</b>					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 <input type="checkbox"/> WORK AT WORK		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>Apr 14 56</b> to <b>Dec 14 58</b> and last saw her him alive on <b>Dec 12 58</b> Death occurred at <b>6:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>W.D. Schierman, M.D.</b> (Degree or title)			22b. ADDRESS <b>4161 Lindell</b>		22c. DATE SIGNED <b>12-15-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE <b>12-16-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery St. Louis, Missouri</b>		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <b>C. R. Lupton &amp; Sons, 7233 Delmar</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>12-16-58</b>		26. REGISTRAR'S SIGNATURE <b>Herbert R. Plunk, M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

MEDICAL CERTIFICATION

Doctor, coroner, embalmers use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Dr. William Schierman  
4161 Lindell Biv'd.  
JE 3-1870 -  
3:00 To 5:00

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.