

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002995

1003

STATE FILE NUMBER

FILED JAN 26 1959

Registration District No.

318

Primary Registration District No.

Registrar's No.

202

300

1-57

64

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1924 ANGEL ROOT 33 WRS</u> Length of stay in lb		d. STREET ADDRESS <u>226 1924 ANGEL ROOT</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 Middle Last <u>CHARLOTTE GREIMANN</u>			4. DATE OF DEATH Month Day Year <u>JAN. 6 1959</u>		
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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"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 3, 1870</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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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>
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13a. FATHER'S NAME <u>JOHN RUEGG</u>	13b. MOTHER'S MAIDEN NAME <u>do NOT KNOW</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
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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 Address <u>ANNA GREIMANN 1924 ANGEL ROOT</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Occlusion, Hypertension (Senility)</u>		
CONDITIONS, IF ANY, DUE TO (b) <u>Intertrochanteric Fracture Right Femur</u>		
WHICH WOULD BE THE CAUSE OF DEATH IF NOT FOR THE UNDERLYING CAUSE (c) <u>904.0</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 <input checked="" 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.) <u>Fell in the kitchen of her home Dec-26-58</u>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. <u>6</u> p.m. <u>12-26-58</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>
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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>home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>
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21. I attended the deceased from <u>Dec-26-58</u> to <u>Jan-6-59</u> and last saw her alive on <u>Jan-6-59</u> Death occurred at <u>6:00 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>2739 N. Grand Blvd.,</u>	22c. DATE SIGNED <u>I-8-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JAN. 9, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS Co., Mo</u>
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24. FUNERAL DIRECTOR <u>ORTMANN F. HOME</u> ADDRESS <u>9222 LACKLAND OVERLAND Mo</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 8 '59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u> M. J. B.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with asterisk. All diseases in Part I must be causally related.

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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 *Al. C. Oetmann*

Licensed Embalmer No. *3478*

P. O. Address

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.