

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003054  
STATE FILE NUMBER  
2 663

FILED FEB 10 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

300  
1-57  
9  
35  
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Wellston 4301
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O. Baptist Hosp.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5302 Ridge Ave.
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Mary J. Henke			4. DATE OF DEATH Month Day Year 1 18 59		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-1888	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.	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) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Frank Heinz	13b. MOTHER'S MAIDEN NAME Josephine Gress	14. NAME OF HUSBAND OR WIFE Deceased
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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) No None	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. V.V. Masterson 1915 Raft Dr.	Address
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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: IMMEDIATE CAUSE (a) <i>Generalized Peritonitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>2 mos.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Abscess of rt lobe of liver</i> DUE TO (c) <i>582X</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <i>14 Jan 59</i> to <i>18 Jan 59</i> and last saw <i>her</i> alive on <i>18 Jan 59</i> Death occurred at <i>7 A. m</i> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Richard A. Jones MD</i> (Degree or title)	22b. ADDRESS <i>3720 Washington</i>	22c. DATE SIGNED <i>1-19-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1-21-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Peter &amp; Paul</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Missouri</i>
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24. FUNERAL DIRECTOR <i>Jos. W. Clark F.H.</i> ADDRESS <i>1125 Modiamont Ave.</i>	25. DATE RECD. BY LOCAL REG. <i>JAN 20 '59</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *John J. Haines* .....

Licensed Embalmer No. *4108* .....

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.