Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003279
STATE FILE NUMBER

FILED FEB 4 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 667

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST LOUIS, — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 4632 KENNERLY AVE — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI — b. COUNTY
c. CITY OR TOWN: ST LOUIS, 2119 0 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4632 KENNERLY AVE — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: MARY — Middle: T. — Last: MENKE

4. DATE OF DEATH: Month: JAN, Day: 18, Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED [XX] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: APRIL 27, 1883

9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): ST LOUIS MISSOURI 0

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: PETER McNIFF

13b. MOTHER'S MAIDEN NAME: MARY FITZGERALD

14. NAME OF HUSBAND OR WIFE: JOHN W. MENKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: JOHN W. MENKE — Address: 4632 KENNERLY AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): General arteriosclerosis
DUE TO (c): 331X

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 [ ] NO [X] 2

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

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 [ ] NOT WHILE 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 Jan. 15, 1959 to Jan 18, 1959 and last saw her alive on Jan. 18, 1959
Death occurred at 5:20 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Henry C. Westerman, M. D.

22b. ADDRESS: 2136 East Grand Blvd

22c. DATE SIGNED: 1-19-59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 1/21/59

23c. NAME OF CEMETERY OR CREMATORY: CALVARY CEMETERY

23d. LOCATION (City, town, or county) (State): ST LOUIS MISSOURI

24. FUNERAL DIRECTOR: STROOT - CARROLL — **ADDRESS**: 4600 NATURAL BRIDGE AVE

25. DATE RECD. BY LOCAL REG.: JAN 20 '59

26. REGISTRAR'S SIGNATURE: J Earl Smith MD
MDB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 M W Rueter

Licensed Embalmer No. 4865

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.