

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004026

STATE FILE NUMBER

FILED FEB 10 1959

Registration District No.

317

Primary Registration District No.

500

Registrar's No.

336

300

57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Acfton 4810</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>Normandy Osteopathic Hosp</u>		Length of stay in lb <u>2 wks.</u>	d. STREET ADDRESS (If outside, give location) <u>4864 Heidelberg</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Phillip</u> Middle <u>Herman</u> Last <u>Rengier</u>			4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1890</u>	9. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Factory + Grocery</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Anton</u>		13b. MOTHER'S MAIDEN NAME <u>Palmer</u>		14. NAME OF HUSBAND OR WIFE <u>Rose</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>1st World War</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT <u>Son - Jerome - 4864 Heidelberg</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EXSANGUINATION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Gastro-Intestinal Hemorrhage</u> DUE TO (c) <u>Myelogenous Leukemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Thrombocytopenia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>1 year</u>
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 <u>2:34</u> Month <u>2</u> Day <u>2</u> Year <u>1959</u> a.m. p.m.					
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 <u>1-18-59</u> to <u>2-2-59</u> and last saw <sup>her</sup> him alive on <u>2-1-59</u> Death occurred at <u>2:34</u> a m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert W. Shelby DO</u>		22b. ADDRESS <u>1917 N. Hanley St. Louis 14</u>		22c. DATE SIGNED <u>2-2-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>FEB. 5 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>	
23d. LOCATION (City, town, or county) <u>ST. LOUIS</u>		(State) <u>Mo.</u>			
24. FUNERAL DIRECTOR <u>Thomas Kuter 2906 Gravis</u>		25. DATE RECD. BY LOCAL REG. <u>2-3-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

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 *E. E. ...* .....

Licensed Embalmer No. *3403* .....

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.