Health, Welfare Public Service

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1-57

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007085
STATE FILE NUMBER

FILED MAR 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 1722

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Jewish Hosp. — 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 — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 5321 Delmar — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: EMBRY Middle: D. Last: FAATZ

4. DATE OF DEATH: Month 2 Day 18 Year 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: 12/7/87

9. AGE (In years last birthday): 71 — 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): Retired Shipping Clk.

10b. KIND OF BUSINESS OR INDUSTRY: Wellandy Blackland

11. BIRTHPLACE (City and state or country): Fargo, N. Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Arthur Faatz

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Clara Faatz

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.: 488-18-0361A

17. INFORMANT: Helen E. Pipes — Address: 3804 Calvert Overland Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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)	Pulmonary edema	5 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cardiac failure	2 hrs.
DUE TO (c)	Renal failure 593X	2 wks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Staphylococcal septicemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

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 July 1958, to February 1959 and last saw him alive on 2/17/59. Death occurred at 3:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Keith E. Pipes, M.D.

22b. ADDRESS: 216 So. Kingshighway, St. Louis

22c. DATE SIGNED: 2/18/59

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

23b. DATE: 2/18/59

23c. NAME OF CEMETERY OR CREMATORY: Linwood Cem.

23d. LOCATION (City, town, or county) (State): Dubuque Iowa

24. FUNERAL DIRECTOR: Oltmann J. Home — **ADDRESS**: 9222 Lackland, Overland (Licensed Embalmer's Statement on Reverse Side)

25. DATE RECD. BY LOCAL REG.: FEB 18 '59

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

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. Ortmann....

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.