

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007131

STATE FILE NUMBER

2 1298

FILED FEB 17 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300

357

191

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|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</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>BARNES HOSPITAL</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>5300 Tholozan Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE NNN GEIST</u> | | | 4. DATE OF DEATH Month Day Year <u>FEBRUARY 4, 1959</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 18, 1903</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeping</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 9. AGE (In years last birthday) <u>55</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. |
| 11. BIRTHPLACE (City and state or country) <u>Austria-Hungary</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Phil. Urschel</u> | | 13b. MOTHER'S MAIDEN NAME <u>Margaret Kirschner</u> | 14. NAME OF HUSBAND OR WIFE <u>Andrew Geist</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | 17. INFORMANT Address <u>Andrew Geist - 5300 Tholozan Ave.</u> |
| 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>ACUTE MASSIVE PULMONARY EMBOLISM</u> DUE TO (b) <u>PHLEBOTHROMBOSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>SEVERE CONGESTIVE HEART FAILURE WITH MITRAL INSUFFICIENCY</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>465X</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 Month, Day, Year 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>JAN. 1, 1959</u> to <u>FEB. 4, 1959</u> and last saw her alive on <u>FEB. 4, 1959</u> Death occurred at <u>10:20 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>C. E. Venellia, M.D.</u> | | 22b. ADDRESS <u>BARNES HOSPITAL</u> | 22c. DATE SIGNED <u>2/5/59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>Feb. 7, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>WACKER-HELDERLE-3634 Gravois Ave.</u> | | 25. DATE RECD. BY LOCAL REG. <u>FEB 6 '59</u> | 26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Felicit J. Krupin*

Licensed Embalmer No. 3497
P. O. Address St. Louis

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.