

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007236

STATE FILE NUMBER

2 1399

Health,
Welfare
Public
Service

FILED FEB 24 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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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 Charles	
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 St Charles
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wood Samaritan Home 10 yrs		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 602 Jackson
3. NAME OF DECEASED (Type or print) First Middle Last Meta Horst		4. DATE OF DEATH Month Day Year Feb. 6 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6 1872
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St Charles Mo
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Fred Horst	
13b. MOTHER'S MAIDEN NAME Carolina Meyer		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Wm Horst St Charles Mo
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>Chr myocarditis</u> DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Senility 420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION COUNTY STATE		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at <u>800 pm</u> on <u>2/2/59</u> to <u>2/7/59</u> and last saw her alive on <u>2/6/59</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>W. F. Neumann M.D.</u> (Degree or title)	
22b. ADDRESS <u>5203 Chipmunk</u>		22c. DATE SIGNED <u>2/9/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 10 1959	23c. NAME OF CEMETERY OR CREMATORY St Johns Cemetery	23d. LOCATION (City, town, or county) (State) St Charles Mo
24. FUNERAL DIRECTOR Arthur C Paue St Charles Mo		25. DATE RECD. BY LOCAL REG. FEB 9 '59	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

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

Not Embalmed.
Signed *Miss Arthur C. Bane*

Licensed Embalmer No.....

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.