

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007441

STATE FILE NUMBER
2-1753

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

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-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>3711 OREGON</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>3711 OREGON</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>CHRISTINE MERKEL</i>			4. DATE OF DEATH Month Day Year <i>FEB. 15 1959</i>	
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5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 25 1878</i>	9. AGE (In years last birthday) <i>80</i>	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RESTAURANT EMPLOYEE</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>ILLINOIS</i>	12. CITIZEN OF WHAT COUNTRY? <i>U-S-A.</i>
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13a. FATHER'S NAME <i>CONRAD MERKEL</i>	13b. MOTHER'S MAIDEN NAME <i>MARY FEIGHT</i>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>488-09-0589</i>	17. INFORMANT <i>MABEL WURTH</i> Address <i>4100 VIRGINIA</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Old age arteriosclerosis</i> DUE TO (c) <i>331X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>2 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <i>July 1940</i> to <i>Feb. 15 59</i> and last saw her alive on <i>Feb. 15 1959</i> Death occurred at <i>7000 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Harlan J. Johnson M.D.</i>	22b. ADDRESS <i>6400 Morganford</i>	22c. DATE SIGNED <i>2-17</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>FEB. 18 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo 59</i>
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24. FUNERAL DIRECTOR <i>Thomas Kuteis 2906 Gravois</i> ADDRESS	25. DATE RECD. BY LOCAL REG. <i>FEB 18 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith. M.D.</i>
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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 *James C. Hill* _____

Licensed Embalmer No. *4347* _____
P. O. Address *2506 1st Ave* _____

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.