Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 59-007536

FILED FEB 17 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 1065

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO. — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis City Hosp. #1 — Length of stay in 1b: 0

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): 1612a Knapp St — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: GERTRUDE — Middle: — Last: PFEIFFER

4. DATE OF DEATH: Month: Jan. Day: 28, Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

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

8. DATE OF BIRTH: 11/15/87

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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (City and state or country): St. Louis Mo.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Charles Kickham

13b. MOTHER'S MAIDEN NAME: Marie Mc Grath

14. NAME OF HUSBAND OR WIFE: Henry

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.:

17. INFORMANT: Gertrude Presti — Address: 1612a Knapp St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE

DUE TO (c) 420.0

INTERVAL BETWEEN ONSET AND DEATH

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

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 1/12/59, to 1/28/59 and last saw her/him alive on 1/28/59

Death occurred at 2:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Lloyd T. Walk, M.D.

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 1/29/59

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

23b. DATE: 1/31/59

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Mo.

24. FUNERAL DIRECTOR: Morrell Mortuary — ADDRESS: 3710 No. Grand

25. DATE RECD. BY LOCAL REG.: JAN 30 '59

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

(Licensed Embalmer's Statement on Reverse Side)

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

Signed Loron E. Siercy

Licensed Embalmer No. 4094

P. O. Address St. Louis, Mo

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.