THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007982
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 428

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Affton — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): #3 Grantview Lane — Length of stay in Ib: 2½ Years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Affton 4870 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): #3 Grantview Lane — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Rose Middle: (N.M.I.) Last: Derringer

4. DATE OF DEATH Month, Day, Year: February 12, 1959

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: September 8, 1892

9. AGE (In years last birthday): 66 — 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: Own Home

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

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Michael Schaefer

13b. MOTHER'S MAIDEN NAME: Rose Rey

14. NAME OF HUSBAND OR WIFE: Peter O. Derringer

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.: None

17. INFORMANT: Peter O. Derringer, Address: #3 Grantview Lane Affton, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic hypertensive cardiovascular disease — 4 yrs.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 443X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 9-2-55 to 2-12-59 and last saw her/him alive on 2-12-59
Death occurred at 5:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M.D.
22b. ADDRESS: 634 N. Grand Blvd.
22c. DATE SIGNED: 2/13/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-16-1959
23c. NAME OF CEMETERY OR CREMATORY: New St. Marcus
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR: Hoffmeister Colonial Mortuary
6464 Chippewa Street, St. Louis, Mo.

25. DATE RECD. BY LOCAL REG.: 2-13-59

26. REGISTRAR'S SIGNATURE: John C. Murphy, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Linus C. Hoffmeis

Licensed Embalmer No. 3871

P. O. Address 7814 S. B

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur 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.