

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011258

STATE FILE NUMBER

FILED APR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2-2959

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</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>St. John'S</u>	Length of stay in lb	d. STREET ADDRESS <u>6017 Gravois</u>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Oldendorf</u> Last <u>Oldendorf</u>	4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1959</u>
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5. SEX <u>Male</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>2-4-1901</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months _____ Days _____	IF 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) <u>Shoe Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Kalmon Shoe Co.</u>	11. BIRTHPLACE (City and state or country) <u>Unknown Missouri.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Oldendorf</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Weingarten</u>	14. NAME OF HUSBAND OR WIFE <u>Helen Oldendorf</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>489-01-4299</u>	17. INFORMANT <u>Helen Oldendorf</u>	Address <u>6017 Gravois</u>
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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) <u>acute arterial myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 days</u>
DUE TO (b) <u>atherosclerotic Heart Disease</u>		
DUE TO (c) <u>420.0</u>		<u>2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Premature aortic infarction</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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 _____ 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 _____
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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 _____
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21. I attended the deceased from <u>10-3-56</u> to <u>3-22-59</u> and last saw her alive on <u>3-21-59</u> Death occurred at <u>405</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Arthur K. Truesdel M.D.</u>	22b. ADDRESS <u>7500 Devonshire</u>	22c. DATE SIGNED <u>3-23-1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-25-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus</u>	23d. LOCATION (City, town, or county) (State) <u>7901 Gravois Mo.</u>
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24. FUNERAL DIRECTOR <u>Biegher Bros.</u>	ADDRESS <u>6409 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>3-24-1959</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

vector, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

300
1-57
25
294
C

MEDICAL CERTIFICATION

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 *Jay M. Sigmon*
Licensed Embalmer No. 4343

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.