

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011468  
STATE FILE NUMBER  
2413

FILED MAR 20 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Saint Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7515 Vermont Ave.</b>		Length of stay in 1b <b>35 Years</b>	d. STREET ADDRESS (If outside, give location) <b>7515 Vermont Ave. (11)</b> Reside on Farm es <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>E.</b> Last <b>UHLINGER</b>			4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1886</b>	9. AGE (In years) <b>73</b>	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, give war or retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>(Retired)</b>	11. BIRTHPLACE (City and state or country) <b>Centalia, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Uhlinger</b>	13b. MOTHER'S MAIDEN NAME <b>Nancey Prasise</b>	14. NAME OF HUSBAND OR WIFE <b>Anna (Deceased)</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>493-10-2901</b>	17. INFORMANT <b>Harrison Uhlinger</b>	Address <b>3836 Osceola St. (16)</b>
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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) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Ch. Hypertensive Heart Disease</b>		<b>2 years</b>
	DUE TO (c) <b>420.1</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2.	

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. 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 <b>March 1, 1959</b> to <b>March 6-59</b> and last saw him alive on <b>March 4, 1959</b> Death occurred at <b>2:45 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Oliver J. M. James</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>7619 IVORY Ave</b>	22c. DATE SIGNED <b>3/7/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Mar. 9, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Clive Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Lemay (25) Missouri.</b>
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24. FUNERAL DIRECTOR <b>Fendler Und. Co.</b>	ADDRESS <b>7420 Michigan (11)</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 9 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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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 *W. G. Peterson* .....

Licensed Embalmer No. *3767*  
P. O. Address *7420 Michigan*

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.