

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011635
STATE FILE NUMBER

APR 14 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 923

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN LEMAY 4870
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSP.		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 1225 DAMMERT
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First SELMA Middle Last POENACK			4. DATE OF DEATH Month April Day 3 Year 1959		
--	--	--	--	--	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 4 1868	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
-------------------------	----------------------------------	--	---------------------------------------	--	---	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) GERMANY 4	12. CITIZEN OF WHAT COUNTRY? U - S - A
--	---	--	--

13a. FATHER'S NAME CONRAD RASCHDORF	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE RICHARD POENACK (Dfcb)
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT CONRAD MUEHLFARTH 1225 DAMMERT
--	--	--

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
DUE TO (b) Arteriosclerotic Heart Disease		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Symptoma of Neph		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.) 4200
---	---

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
---	---	--	--

21. I attended the deceased from 2-25-59 to 4-3-59 and last saw her alive on 4-3-59 Death occurred at 10:55 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Gene H. Page, M.D.	22b. ADDRESS 601 S. Brentwood Clayton 5, Mo	22c. DATE SIGNED 4-4-59
---	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE APRIL 6 1959	23c. NAME OF CEMETERY OR CREMATORY MISSOURI CREMATORY	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO
---	----------------------------------	---	--

24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois	25. DATE RECD. BY LOCAL REG. 4-6-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
--	---	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *E. L. Dornice*

Licensed Embalmer No. *3408*

P. O. Address *Summers*

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.