

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016250
STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1211

3707 Watson Rd.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 Affton		c. CITY OR TOWN Affton 4820	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 9935 Vasel Drive		d. STREET ADDRESS (If outside, give location) 9935 Vasel Drive	
Length of stay in 1b YRS.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) MARGARET BLUM			4. DATE OF DEATH 5-1-1959		
First	Middle	Last	Month	Day	Year

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-1977	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	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) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ??? Schaar	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE unk.
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Ernest Blum	Address 9935 Vasel Drive
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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) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 hrs
DUE TO (b) Arteriosclerosis, Coronary		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 Feb 3, 1951 to May 1, 1959 and last saw her alive on May 1, 1959 Death occurred at 7 AM on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE John S. Matthews M.D. (Degree or title)	22b. ADDRESS 3707 Watson Rd	22c. DATE SIGNED 5-1-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-4-1959	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) (State) 10160 Gravois Rd Mo
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24. FUNERAL DIRECTOR Biegenheim Bros	ADDRESS 6409 Gravois	25. DATE RECD. BY LOCAL REG. 5-4-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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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 *John M. Seymour*

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.