

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016331

STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1150

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 SUNSET HILLS		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN SUNSET HILLS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2497 Lindberg Blvd. 2 Yrs.			Length of stay in 1b			d. STREET (If outside, give location) ADDRESS 2497 Lindberg Blvd.	
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Josephine Michel				4. DATE OF DEATH Month 4 Day 27 Year 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1878	
9. AGE (In years last birthday) 81		10. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and state or country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Campere				14. MOTHER'S MAIDEN NAME Unknown			
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 Margaret Fox 2497 Lindberg Blvd. St. Louis Co. Mo.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____						INTERVAL BETWEEN ONSET AND DEATH 1 week years	
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.) 334X	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
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	
21. I attended the deceased from Dec 58 to April 59 and last saw her alive on 15 Apr 59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Joseph G. Ernst MD				22b. ADDRESS 11774 Manchester St. St. Louis		22c. DATE SIGNED 27 Apr 59	
23a. BURIAL (CREMATION) REMOVAL (Specify) Removal		23b. DATE 4-27-59		23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) (State) Edwardsville, Illinois	
24. FUNERAL DIRECTOR Pieper Funeral Home		ADDRESS Granite City Ill.		25. DATE RECD. BY LOCAL REG. 4-28-59		26. REGISTRAR'S SIGNATURE John C. Murphy M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 NOT EMBALMED, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed Henry J. Biepe
Licensed Embalmer No. _____

P. O. Address Chambers

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