

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016376

STATE FILE NUMBER

FILED MAY 7 1959

7 1959

Registration District No.

317

Primary Registration District No.

500

Registrar's No.

893

300
1-57
1
1/1
0

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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>Robert Koch Hosp.</u>		Length of stay in lb <u>7 days</u>		d. STREET ADDRESS (If outside, give location) <u>7307 S. Grand</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle _____ Last <u>West</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 15, 1883</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>St Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Adam Kramer</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Runkel</u>			14. NAME OF HUSBAND OR WIFE <u>Henry West</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT Address <u>Echard West 7311 So. Grand St. Louis, Mo.</u>			
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>Cerebral thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>332XA</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>chronic pulmonary tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u>	
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.)					
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 <u>March 25, 1959</u> to <u>April 1, 1959</u> and last saw her alive on <u>April 1, 1959</u> Death occurred at <u>April 1, 1959 2:10 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Axel R. Lorenson, M.D.</u> (Degree or title)				22b. ADDRESS <u>Robert Koch Hospital Koch Mo.</u>		22c. DATE SIGNED <u>4-1-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Apr. 4, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lemay, Missouri</u>	
24. FUNERAL DIRECTOR <u>Hofmeister Mortuaries</u> 7814 So. Broadway St. Louis, Mo.			25. DATE RECD. BY LOCAL REG. <u>4-2-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Rice C. Brannon*

Licensed Embalmer No. *4764*

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.