

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016378
STATE FILE NUMBER

FILED APR 27 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1087

300
-57

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) Normandy		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Manchester 4000
c. FULL NAME OF (If NOT in hospital, give location) Normandy Osteopathic		Length of stay in lb 10 1/2 HRS.	d. STREET ADDRESS (If outside, give location) P.O. Box 293
3. NAME OF DECEASED First Robert Middle Clyde Last Westerhold Jr.			4. DATE OF DEATH Month 4 Day 20 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months 1 Days 8 1/2 IF UNDER 24 HRS.: Hour 8 1/2 Min.
11. BIRTHPLACE (City and state or country) Normandy, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Robert Clyde Westerhold		13b. MOTHER'S MAIDEN NAME Leda Elizabeth Sherfy	14. NAME OF HUSBAND OR WIFE none
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 ROBERT WESTERHOLD Address MANCHESTER
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) atalectasis DUE TO (c) renaluremia			INTERVAL BETWEEN ONSET AND DEATH 7625
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.) 7625	
20c. TIME OF INJURY Hour 4:00 Month 4 Day 20 Year 1959		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.) NORMANDAY		20f. CITY, TOWN, OR LOCATION St Louis COUNTY Missouri STATE	
21. I attended the deceased from 9 AM 3 AM 4-19-59 to 9 AM 4-20-59 and last saw her alive on 4-20-59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W.D. Gardner M.D. (Degree or title)		22b. ADDRESS 917 Airport Rd	22c. DATE SIGNED 4/21/59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	4-21-59	FRIEDENS	ST LOUIS Co Mo.
24. FUNERAL DIRECTOR Fred C. Henke ADDRESS 4911 WASHINGTON		25. DATE RECD. BY LOCAL REG. 4-21-59	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.

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

*Not Embalmed
Due to Health*

Signed

Licensed Embalmer No.....

P. O. Address.....

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.