

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018829
STATE FILE NUMBER

FILED MAY 18 1959 Registration District No. 310 Primary Registration District No. 6051 Registrar's No. 117

300
1-57

1. PLACE OF DEATH a. COUNTY ST. CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. CHARLES	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. CHARLES		c. CITY OR TOWN ST. CHARLES	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RP 4 Box 401		Length of stay in lb 43 YRS	
3. NAME OF DECEASED (Type or print) First Middle Last JULIA O HEMSATH		4. DATE OF DEATH Month Day Year MAY 3 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 8 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY IN OWN HOME	11. BIRTHPLACE (City and state or country) ST. CHARLES MO
13a. FATHER'S NAME GEORGE BERLEKAMP		13b. MOTHER'S MAIDEN NAME META DIEKAMP	14. NAME OF HUSBAND OR WIFE HERMAN E. HEMSATH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NOT		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address HERMAN E. HEMSATH, ST. CHARLES MO
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis DUE TO (b) hypertension + Mitral Insufficiency DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443X			INTERVAL BETWEEN ONSET AND DEATH Sept 1957 to May 3rd 1959
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from Sept 1957 to May 3rd and last saw her alive on May 2nd 1959 Death occurred at 1:15 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
22a. SIGNATURE Dr. H. Hughes M.D. (Degree or title)		22b. ADDRESS 2007 Main St. Charles Mo	
22c. DATE SIGNED 5/4/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 5 1959	
23c. NAME OF CEMETERY OR CREMATORY FRIEDENS CEM		23d. LOCATION (City, town, or county) (State) ST. CHARLES CO. MO	
24. FUNERAL DIRECTOR C. H. PRINSTER ADDRESS ST. CHARLES MO		25. DATE RECD. BY LOCAL REG MAY 4-59	
26. REGISTRAR'S SIGNATURE Marceen Wilson			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

PRINSTER-HUGHES INC.

(Licensed Embalmer's Statement on Reverse Side)

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 *Howard A. Kessler*

Licensed Embalmer No. *4631*

P. O. Address *Wentzville,*

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.