Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019541
STATE FILE NUMBER

FILED MAY 18 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 4442

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Little Flower Con, 2 mos — Length of stay in 1b: 4

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3615 Michigan — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Emily — Middle: H. — Last: Queensen

4. DATE OF DEATH: Month 5 Day 3 Year 59

5. SEX: FM 1

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 5/20/1883

9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): St. Louis

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Jacob (Jacobs)

13b. MOTHER'S MAIDEN NAME: Barbara John

14. NAME OF HUSBAND OR WIFE: Fred (deceased)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Fred Queensen — Address: 3843 Castleman

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Heart Failure	2 Months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. — DUE TO (b)	Arteriosclerotic Heart Disease	5 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 420.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 February 20, 1959 to May 3, 1959 and last saw her alive on May 3, 1959
Death occurred at 7:45 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Leonard D. Piccione M.D.

22b. ADDRESS: 6303 Natural Bridge Pine Lawn Mo.

22c. DATE SIGNED: 5-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 5/6/59

23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park

23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Schumacher — **ADDRESS**: 3013 Mermaec

25. DATE RECD. BY LOCAL REG.: MAY 6 '59

26. REGISTRAR'S SIGNATURE: Neal Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Ct. 6-9373

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 Jack Haupt

Licensed Embalmer No. 4746

P. O. Address St Louis

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.