

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019881

STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 317

Primary Registration District No. 544

Registrar's No. 1404

300
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>)					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kirkwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Ellisville 4000</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>St. Joseph Hosp.</u>		Length of stay in lb <u>18 days</u>		d. STREET ADDRESS (If outside, give location) <u>Wolff Lane</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>H.</u> Last <u>Litzsinger</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1959</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8 1889</u>		9. AGE (In years last birthday) <u>69</u>	10. MONTHS UNDER 1 YEAR	11. DAYS UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale Fruit & Produce</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Edward Litzsinger</u>			13b. MOTHER'S MAIDEN NAME <u>Ida K. Helmke</u>			14. NAME OF HUSBAND OR WIFE <u>Otella M. Faifer</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>		16. SOCIAL SECURITY NO. <u>498-05-1573</u>		17. INFORMANT <u>Ralph Schrick Ellisville, Mo.</u>				Address	
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>CEREBRO-VASCULAR ACCIDENT</u>							INTERVAL BETWEEN ONSET AND DEATH <u>18 DAYS</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>							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) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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 <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>1-17-57</u> to <u>5-18-59</u> and last saw ^{her} _(him) alive on <u>5-18-59</u> Death occurred at <u>6:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Dale H. Blaudenship M.D.</u>				(Degree or title) <u>0</u>		22b. ADDRESS <u>Ballwin, Mo.</u>		22c. DATE SIGNED <u>5-19-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>				
24. FUNERAL DIRECTOR <u>Schrader Funeral Home Ballwin Mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>5-20-59</u>		26. REGISTRAR'S SIGNATURE <u>John L. 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 *Richard Bopp*

Licensed Embalmer No. *4584*

P. O. Address *Bellwin*

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.