

**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-022541**

FILED JUL 7 1959

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 157

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St Charles</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Louis</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St Charles</b>		Length of stay in 1b <b>2 da</b>		c. CITY OR TOWN <b>Maryland Hgts</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Josephs Hosp</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Fee Fee &amp; Dorsett Rds</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>FitzGerald</b> Last <b>Gerald</b>				4. DATE OF DEATH Month <b>7</b> Day <b>2</b> Year <b>1959</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/5/74</b>		9. AGE (last birthday) <b>84</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Florissant Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>John Pohlman</b>				13b. MOTHER'S MAIDEN NAME <b>Bridget Mansfield</b>				14. NAME OF HUSBAND OR WIFE <b>Marcella Zahner Maryland Hgt</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Marcella Zahner Maryland Hgt</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic Heart Disease</b> DUE TO (c) <b>years</b>										INTERVAL BETWEEN ONSET AND DEATH <b>abrupt</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Melana, Cause Undtd</b>										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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. Month, Day, Year													
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 <b>2 April 55</b> , to <b>2 July 59</b> and last saw her/him alive on <b>27 June 59</b> Death occurred at <b>11:55P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>H. E. Hengen MD</b> (Degree or title)				22b. ADDRESS <b>Bridgeton Mo</b>				22c. DATE SIGNED <b>3 July 59</b> (State)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7/6/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Ferdinand Cem</b>		23d. LOCATION (City, town, or county) <b>Florissant Mo</b>							
24. FUNERAL DIRECTOR <b>Ortmann F Home 9222 Lackland Overland Mo</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>July 3-59</b>		26. REGISTRAR'S SIGNATURE <b>Marcella Wilson</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Al C Ostmann

Licensed Embalmer No. 3478

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.