

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023303

STATE FILE NUMBER

2 5627

FILED JUN 24 1959		Registration District No. _____		Primary Registration District No. _____		Registrar No. _____	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
3 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>			Length of stay in lb <b>D.O.A.</b>		d. STREET ADDRESS <b>2235 Gasconade</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Adele</b> Middle <b>L.</b> Last <b>Raaf</b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</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 type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 9, 1908</b>		9. AGE (In years last birthday) <b>51</b> IF UNDER 1 YEAR: Months <b>4</b> Days <b>1</b> IF UNDER 24 HRS.: 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 _____		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Albert Jaeggi</b>			13b. MOTHER'S MAIDEN NAME <b>Emma Thuli</b>			14. NAME OF HUSBAND OR WIFE <del>George</del>	
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>Albert Raaf 2235 Gasconade</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>Coronary thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arterio-sclerotic heart disease</b>						4 mo 3 mo	
DUE TO (c) <b>4200</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension and decompensated arterio-sclerotic heart disease</b>						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 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.) <b>St. Louis</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>		COUNTY _____ STATE _____	
21. I attended the deceased from <b>Feb 8 1958</b> to <b>June 10 1959</b> and last saw her alive on <b>June 6 1959</b> Death occurred at <b>4:30 P.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Max Stanbly M.D.</b> (Degree or title)				22b. ADDRESS <b>512 Olive Ave</b>		22c. DATE SIGNED <b>6/12/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 13, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>		
24. FUNERAL DIRECTOR <b>Schumacher's 3013 Meramec St.</b>			25. DATE RECD. BY LOCAL REG. <b>JUN 12 '59</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> m & B.		

(Licensed Embalmer's Statement on Reverse Side)

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAX STARKLOFF  
FRIDAY 12:00 TO 6:00 P.M.  
512 DOVER

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.