

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023463

STATE FILE NUMBER

2 6124

FILED JUL 13 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

S. 300

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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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hosp		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 4937 Loughborough Ave Reside on Farm No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First KATHERINE Middle Last TILLGER			4. DATE OF DEATH Month 6 Day 27 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1980
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME ????? Kampf		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Pauline Weckersmeyer Address 1819 S. 8th. St
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary Artery Thrombosis DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive Cardio-vascular disease			INTERVAL BETWEEN ONSET AND DEATH 9 days 9 days
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year 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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 6/19/59 to 6/27/59 and last saw her ^{her} alive on 6/26/59 Death occurred at 2:30 A. m of the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Edward W. Czernuski M.D.		22b. ADDRESS 3701 Grand St.	22c. DATE SIGNED 6/27/59
23b. BURIAL, CREMATION, REMOVAL (Specify) Removal	23c. DATE 6-29-1959	23d. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23e. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Rd. Mo
24. FUNERAL DIRECTOR Biegenheim Bros ADDRESS 6409 Gravois Ave		25. DATE RECD. BY LOCAL REG. JUN 29 1959	26. REGISTRAR'S SIGNATURE Neal Smith, M.D.

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 *Laurence O Gerking*

Licensed Embalmer No. *4979*
P. O. Address *St. Louis, Mo.*

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.