

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023602
STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1546

300
-57

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1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		c. CITY OR TOWN Normandy 4171	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION County Hosp.		d. STREET ADDRESS (If outside, give location) 5346 Gladstone Ave.	
Length of stay in lb DOA		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth M. Pickel			4. DATE OF DEATH Month Day Year 6-3-59		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-89	9. AGE (In years last birthday) 71	IF FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mortuary Reception	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) France	12. CITIZEN OF WHAT COUNTRY? 2 USA
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13a. FATHER'S NAME Conrad Raesch	13b. MOTHER'S MAIDEN NAME Marie Link	14. NAME OF HUSBAND OR WIFE Harry C. Pickel
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. 498-20-9160A	17. INFORMANT Address Oliver J. Pickel 6520 Woodrow
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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, probable sudden		INTERVAL BETWEEN ONSET AND DEATH 4 201
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

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.)
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20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from **Jan 23, 1956** to **June 3, 1959** and last saw her ^{him} alive on **June 1, 1959**
Death occurred at **2:00 PM** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) Arthur J. Pickel, MD.	22b. ADDRESS 4110 West Florissant	22c. DATE SIGNED June 6, 1959
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23a. BURIAL, CREMATION, or ENOVAL (Specify) Removal	23b. DATE 6-6-59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR ADDRESS White-Mullen 118 N. Florissant Rd.	25. DATE RECD. BY LOCAL REG. 6-5-59	26. REGISTRAR'S SIGNATURE John C. Murphy MD.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Reinholtz & Lohmann*

Licensed Embalmer No. *9395*

P. O. Address *Fergusen 35*

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.