

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 24 1959

59-026713

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 6372** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. ANTHONY Hosp.		d. STREET ADDRESS (If outside, give location) 3615 JUNIATA	

3. NAME OF DECEASED (Type or print) First HUGO Middle O. Last HAERTING			4. DATE OF DEATH Month JULY Day 3 Year 1959				
5. SEX MALE	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 NOV. 21 1895	9. AGE (last birthday) 63	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY ELY-WALKER		11. BIRTHPLACE (City and state or country) ST. LOUIS, MO		12. CITIZEN OF WHAT COUNTRY U-S-A	

13a. FATHER'S NAME HUGO O HAERTING SR.		13b. MOTHER'S MAIDEN NAME LINDA HUBENSCHMIDT		14. NAME OF HUSBAND OR WIFE ADELE HAERTING	
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. 490-03-9257		17. INFORMANT Address DOROTHY KLEIN, FLORISSANT Mo	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Epilepsy			
DUE TO (b) Cholesterol Occlusion			
DUE TO (c) Arterio sclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AL. OPSY 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.) 353.3	
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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph E. Schubert Deputy Coroner		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 7/6/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE JULY 7 1959		23c. NAME OF CEMETERY OR CREMATORY RESURRECTION Cem.	
24. FUNERAL DIRECTOR Thomas Kutas 2906 Gravis		25. DATE RECD. BY LOCAL REG. JUL 6 '59		23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo	
26. REGISTRAR'S SIGNATURE Harold Smith M.D.					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Carver

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 _____, _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Eleanora*

Licensed Embalmer No. *340*

P. O. Address *2906 Jr*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.