

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026840

FILED VS JUL 3 0 1959

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's 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>		Length of stay in 1b	c. CITY OR TOWN <b>St Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5212 Nagel</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>5212 Nagel</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>Olga</b> Middle <b>C</b> Last <b>Kilton</b>			4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1959</b>			
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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>Dec 21, 1872</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Peoria, Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Emil J Huber</b>	13b. MOTHER'S MAIDEN NAME <b>Louisa Sehmer</b>	14. NAME OF HUSBAND OR WIFE
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mrs Robert E Kelley</b>	Address <b>5212 Nagel</b>
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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) <b>General cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Coronary sclerosis</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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Peoria, Ill.</b>	COUNTY	STATE
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21. I attended the deceased from **4/29/57** to **7/21/59** and last saw her <sup>her</sup> alive on **7/19/59**.  
Death occurred at **1:45** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Arthur E. Strauss M.D.</b> (Degree or title)	22b. ADDRESS <b>3890 Washington</b>	22c. DATE SIGNED <b>7/21/59</b> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7/23/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Springdale Cemetery</b>	23d. LOCATION (City, town, or county) <b>Peoria, Ill.</b>
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24. FUNERAL DIRECTOR <b>John L Ziegenhein &amp; Sons 7027 Gravois</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JUL 22 1959</b>	26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b>
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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 r

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Donald Perry*

Licensed Embalmer No. *4863*

P. O. Address *St. James 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.