

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027019

FILED VS JUL 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **6490**

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 5 yrs.		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 5758 Vivian Ave.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5758 Vivian Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Emma Nunnenkamp				First	Middle	Last	4. DATE OF DEATH Month 7 Day 8 Year 59			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11/12/78	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Henry C. Munnenkamp			13b. MOTHER'S MAIDEN NAME Hanna Moenkeman			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 Miss Clara Nunnenkamp Address 5758 Vivian Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Coronary Occlusion</i></u> acute DUE TO (b) <u><i>Valvular disease</i></u> DUE TO (c) <u><i>57y</i></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 421.4						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				
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.		Month, Day, Year								
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 <u><i>19 53</i></u> to <u><i>19 59</i></u> and last saw her/him alive on <u><i>4 pm 7/8-59</i></u> . Death occurred at <u><i>6:00</i></u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <i>James O. Gehr M.D.</i> (Degree or title)				22b. ADDRESS <i>2505 Mt. Pleasant</i>				22c. DATE SIGNED <i>7-9-59</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 7/10/59	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery			23d. LOCATION (City, town, or county) St. Louis		STATE Mo.		
24. FUNERAL DIRECTOR Drehmann-Harral ADDRESS 1905 Union			25. DATE RECD. BY LOCAL REG. JUL 9 '59		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>					

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Warren A. Carver

Licensed Embalmer No. 353

P. O. Address _____

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