

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH 59-027054

FILED VS JUL 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-6325** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital-D.O.A.</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS <b>1363 Graham Ave.</b> (If outside, give location) Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>HULDA</b> Middle <b>F.</b> Last <b>PEISTRUP</b>	<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>1</b> Year <b>1959</b>
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10-25-02</b>	<b>9. AGE (last birthday)</b> <b>56</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis, Mo.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
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<b>13a. FATHER'S NAME</b> <b>William H. Mittendorf</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Katherine Scheer</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Late Frank W. Peistrup</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT</b> Address <b>Laura Krieg 5945 Loughborough Av.</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anterior Myocardial infarction, acute, accompanied by terminal acute interstitial pneumonitis</b> DUE TO (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH  
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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
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
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<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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21. I attended the deceased from \_\_\_\_\_ 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.

<b>22a. SIGNATURE</b> (Degree or title) <i>Patrick J. Taylor</i>	<b>22b. ADDRESS</b> <b>1300 Clark</b>	<b>22c. DATE SIGNED</b> <b>7.3.59</b> (State)
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	<b>23b. DATE</b> <b>July 6, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Resurrection Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) <b>St. Louis Co. Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Kriegshauser 4228 S.Kingshighway</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>JUL 3 '59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Paul Smith, M.D.</i>
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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

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

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Geo. H. Kriegshamer, Jr.*

Licensed Embalmer No. 4988

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.