

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027401

FILED VS AUG 3 1959

Registration District No. 17 Primary Registration District No. 541 Registrar's No. 2019 STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u> Length of stay in 1b <u>36 DAYS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS Co. HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST LOUIS</u> c. CITY OR TOWN <u>WEBSTER GROVES Mo</u> (Inside Limits) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>935 PROVIDENCE</u> (Reside on Farm) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last <u>MAMIE AMELIA AWINBAUH</u>			4. DATE OF DEATH Month Day Year <u>7-29-59</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-1876</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>23</u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JOHN AWINBAUH</u>			13b. MOTHER'S MAIDEN NAME <u>MARY TEASDALE</u>			14. NAME OF HUSBAND OR WIFE <u> </u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Her husband 935 Providence Ave</u>
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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) <u>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterial Hypertension</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>unknown</u> <u>2-4 yrs.?</u>
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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) <u>Hepatic Cirrhosis, Cerebral Edema, ASHD.</u>	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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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.) <u> </u>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u> </u>		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.) <u> </u>
20f. CITY, TOWN, OR LOCATION COUNTY STATE <u> </u>		20g. CITY, TOWN, OR LOCATION COUNTY STATE <u> </u>	

21. I attended the deceased from June 23-1959 to July 29-1959 and last saw her alive on July 29-1959
 Death occurred at 6²⁰ A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul W. Schaper M.D.</u>	22b. ADDRESS <u>601 S. BRENTWOOD Bl.</u>	22c. DATE SIGNED <u> </u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-30-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKE CHARLES Cem</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS Co Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>MITTELBERG WEBSTER GROVES Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7-29-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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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 _____

Not Embalmed

Licensed Embalmer No. _____

P. O. Address _____

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.