

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027557

FILED VS AUG 10 1959

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2078 STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in lb <b>11 hrs.</b>	c. CITY OR TOWN <b>Clayton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>#5 Del-Lin</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>THERESA</b> Middle <b>DEUTSCHMANN</b> Last <b>DEUTSCHMANN</b>			4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-1-1959</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	IF UNDER 24 HR Hours <b>11</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	11. BIRTHPLACE (City and state or country) <b>Richmond Heights, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Louis Deutschmann</b>		13b. MOTHER'S MAIDEN NAME <b>Barbara Tuthill</b>		14. NAME OF HUSBAND OR WIFE <b>Infant</b>	
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>Louis Deutchmann-#5 Del-Lin</b> Address <b>Clayton, Mo.</b>		
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>Cerebral</b> DUE TO (b) <b>Undetermined</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)					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)				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 AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <b>11</b> 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 <b>Aug 1, 59</b> to <b>Aug 1, 59</b> and last saw her <b>Aug 1, 59</b> alive on <b>Aug 1, 59</b> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22. SIGNATURE (Degree or Title) <b>C. H. Smith, M.D.</b>			22b. ADDRESS <b>8505 Helmer Blvd</b>		22c. DATE SIGNED <b>8/2/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-3-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Kirkwood 22, Missouri</b>		
24. FUNERAL DIRECTOR <b>Pfzinger Mort-Kirkwood 22, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>8-3-59</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>	

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 This Body was not Embalmed Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student: \_\_\_\_\_  
Signature of Student Embalmer

Signed Herbert J. Lee Jr.

Licensed Embalmer No. 4800

P. O. Address Nikwood

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.