

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-027686  
STATE FILE NUMBER

FILED VS JUL 21 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1756

v. S. 300  
ev. 1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Normandy</b> <b>4171.</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>3731 Oakmount</b>		Length of stay in lb <b>10 yrs.</b>	d. STREET ADDRESS <b>3731 Oakmount</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LILY</b> Middle <b>MARIE</b> Last <b>HERTICH</b>			4. DATE OF DEATH <b>June 29, 1959</b> Month <b>June</b> Day <b>29</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 type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1889</b>	9. AGE (In years last birthday) <b>69</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS. Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Henry Osterman</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Kerney</b>	
14. NAME OF HUSBAND OR WIFE <b>Henry G. Hertich</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>Tom Hertich</b>		Address <b>3731 Oakmount</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 Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis</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>331X</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b>
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.) <b>none</b>			
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 checked="" type="checkbox"/> <b>none</b>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <b>none</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>		COUNTY <b>Mo.</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>June 29, 59</b> to <b>June 29, 59</b> and last saw her alive on <b>June 29, 59</b> Death occurred at <b>9:30 P</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>M. Stachle MD</b> (Degree or title)			22b. ADDRESS <b>7124 Natural Bridge</b>		22c. DATE SIGNED <b>6-30-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>July 2, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis</b> (State) <b>Mo.</b>
24. FUNERAL DIRECTOR <b>Callen + Kelly 7267</b>			ADDRESS <b>Natural Bridge</b>	25. DATE RECD. BY LOCAL REG. <b>7-1-59</b>	26. REGISTAR'S SIGNATURE <b>John C. Murphy M.D.</b>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *James A. Sammers* .....

Licensed Embalmer No. *4142* .....

P. O. Address *St. Louis* .....

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.