

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030130

FILED VS SEP 8 1959 310

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 196

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY Saint Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Charles		Length of stay in 1b 2 hrs.	c. CITY OR TOWN Saint Charles Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2110 No. 3rd St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Sherry Middle Ann Last Halter			4. DATE OF DEATH Month Aug. Day 22 Year 1959		
---	--	--	--	--	--

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 Aug. 22, 1959	9. AGE (last birthday) 0	IF UNDER 1 YEAR Months 0 Days 0 Hours 2 Min.	IF UNDER 24 HR Days 2 Hours 0 Min.
-------------------------	----------------------------------	---	--	------------------------------------	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Saint Charles, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	--	---	--

13a. FATHER'S NAME Hubert Anthony Halter	13b. MOTHER'S MAIDEN NAME Virginia Lee Boschert	14. NAME OF HUSBAND OR WIFE None
--	---	--

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 Hubert Halter, St. Charles, Mo.	Address
---	--	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Premature separation of Placenta		

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 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 August 22, 1959 to Aug 22, 1959 and last saw her ^{her} alive on Aug 22, 1959 Death occurred at 9:10 p. m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>Cliff Lammers M.D.</i> (Degree or title)	22b. ADDRESS 1144 1/2 Main St. Charles Mo	22c. DATE SIGNED 8-24-59
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 24, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	23d. LOCATION (City, town, or county) (State) Saint Charles, Mo.
--	-----------------------------------	---	--

24. FUNERAL DIRECTOR H.C. Dallmeyer & Sons	ADDRESS St. Charles, Mo.	25. DATE RECD. BY LOCAL REG. Aug 28-59	26. REGISTRAR'S SIGNATURE <i>Marcus Wilson</i>
--	------------------------------------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Body not embalmed
J. R. Am...

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 _____

Licensed Embalmer No. _____

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.