

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030361

FILED VS AUG 27 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-7498** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		Length of stay in 1b	c. CITY OR TOWN St. Louis, Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6010 S. Kingshighway Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ROY Middle A. Last EGELHOFF			4. DATE OF DEATH Month Aug. Day 12th Year 1959			
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1904	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Bridgeport Brass	11. BIRTHPLACE (City and state or country) Jerseyville, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John A. Egelhoff	13b. MOTHER'S MAIDEN NAME Amelia Kirchner	14. NAME OF HUSBAND OR WIFE Patricia N. Egelhoff
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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. 489-03-0836	17. INFORMANT Patricia N. Egelhoff-6010 S. Kings-	Address highway.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Lower nephron nephrosis	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hepatic Coma	10 days
	DUE TO (c) Portal Cirrhosis	Several years
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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from **July 31, 1959** to **Aug. 12, 1959** and last saw him alive on **Aug 11, 1959**
Death occurred at **4:45 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Clemens J. DeLeon M.D.	(Degree or title)	22b. ADDRESS 4161 Len. Rd	22c. DATE SIGNED 8-12-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (MTR)	23b. DATE Aug. 14, 1959	23c. NAME OF CEMETERY OR CREMATORY Jerseyville, Ill.	23d. LOCATION (City, town, or county) (State) Jerseyville, Ill.
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24. FUNERAL DIRECTOR Kriegshauser-4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG. AUG 12 '59	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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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 John A. Khan

Licensed Embalmer No. 4533

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to do so 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.