RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-030635
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7595

DED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.
Length of stay in 1b: 44 yrs, 4 mo 14 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis State Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis, Mo.
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 4439 Holly
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First MATTIE Middle Last MENGES
4. DATE OF DEATH: Month August Day 16, Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4-1-79
9. AGE (last birthday): 80 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nil
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Henry Helmich
13b. MOTHER'S MAIDEN NAME: Lizzie (Zipple)
14. NAME OF HUSBAND OR WIFE: John Menges
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.: ~
17. INFORMANT: John Menges Address: 7416 Woodland Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis
DUE TO (c): Heart failure 450.0
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. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 April 2, 1915, to Aug. 16, 1959 and last saw her alive on Aug. 16, 1959
Death occurred at 8:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Joseph Gagliardo, M.D.
22b. ADDRESS: 5400 Arsenal St., St. Louis, Mo.
22c. DATE SIGNED: 8-16-59

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL: Removal
23b. DATE: 8-18-59
23c. NAME OF CEMETERY OR CREMATORY: Bethany Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.
24. FUNERAL DIRECTOR: Drehmann Harral ADDRESS: 1905 Union Blvd.
25. DATE REC'D BY LOCAL REG.: AUG 17 '59
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. C.P.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by Warren A. Carver, Student Embalmer No. 3534

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Warren A. Carve

Licensed Embalmer No. 3534

P. O. Address St. Louis, Mo

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