

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 11 1959

2 8030 59-030884

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3217 Dodier St</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3217 Dodier St</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>G</u> Last <u>Westhoff</u>			4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-1906</u>	9. AGE (last birthday) <u>52</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ST. Louis, Mo</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Geo H. Westhoff</u>		13b. MOTHER'S MAIDEN NAME <u>Louise Stuhlman</u>		14. NAME OF HUSBAND OR WIFE <u>Theodosia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>489-09-8804</u>		17. INFORMANT <u>Theodosia Westhoff</u> Address <u>3217 Dodier</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary Edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>acute Cardiac Failure</u>		<u>1 week</u>
		DUE TO (c) <u>severe Cardiac</u>		<u>2 months</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>multiple sclerosis 30 years</u>			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.) <u>345X</u>		
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 <u>July 1958</u> to <u>8-28-59</u> and last saw ^{her} him alive on <u>8/28/59</u> Death occurred at <u>8/28/59</u> <u>2:30 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>J. E. Casoff</u>		22b. ADDRESS <u>34001 Knigshofway ST LOUIS</u>		22c. DATE SIGNED <u>8/29/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-31-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial PK</u>	23d. LOCATION (City, town, or county) (State) <u>ST Louis Co Mo</u>	
24. FUNERAL DIRECTOR <u>A. Krow</u> ADDRESS <u>2707 N Grand.</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 29 59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

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 *V E Morris*

Licensed Embalmer No. 3360

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.