

**R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

59-030991

FILED VS AUG 26 1959

Registration District No. 317

Primary Registration District No. 545

Registrar's No. 2231

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MAPLEWOOD</b>	Length of stay in 1b <b>DAYS</b>	c. CITY OR TOWN <b>KIRKWOOD</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>MAPLEWOOD NURSING HOME</b>		d. STREET ADDRESS (If outside, give location) <b>#7 PITMAN PL.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>T</b> Last <b>HESS</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>15</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/25/1880</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>←</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	

13a. FATHER'S NAME <b>WILLIAM C HESS</b>	13b. MOTHER'S MAIDEN NAME <b>PHILLIPINA KELLER</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</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>unk.</b>	17. INFORMANT Address <b>ARTHUR SCHULTE 1028 WHITECLIFF</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>Cardiac Insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8/12/59</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>8/15/59</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>Metastatic Carcinoma of the Prostate</b>	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 **8/12/59** to **8/15/59** and last saw him alive on **8/15/59**.  
Death occurred at **10:25 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Angelo A. Spens M.D.</b>	22b. ADDRESS <b>9313 Manchester Rd.</b>	22c. DATE SIGNED <b>8/17/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8/19/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEM.</b>
23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>		(State)

24. FUNERAL DIRECTOR <b>JOHN L ZIEGENHEIN &amp; SONS 7027 GRAVOIS</b>	25. DATE RECD. BY LOCAL REG. <b>8-19-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
--	--	---

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 L. P. Kudwiel

Licensed Embalmer No. 3877

P. O. Address 7027 9th

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.