

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031082

FILED VS SEP 8 1959 317

Registration District No. _____ Primary Registration District No. 500 Registrar's No. 2335

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Normandy</u>		Length of stay in 1b <u>18 Days</u>	c. CITY OR TOWN <u>Bel-Nor</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>O'Sullivan Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2949 Arlmont Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle _____ Last <u>HAEHLE</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>30,</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/78</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	11. BIRTHPLACE (City and state or country) <u>New Jersey</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Dougherty</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Pollack</u>		14. NAME OF HUSBAND OR WIFE <u>Henry A. Haehle</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>None</u>		17. INFORMANT <u>Frank Henniger 2949 Arlmount Dr.</u> 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) <u>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
DUE TO (b) <u>Arteriosclerotic Heart disease</u>		<u>unknown</u>
DUE TO (c) _____		
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 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 <u>St. Louis</u>	COUNTY <u>St. Louis</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>August 12, 1959</u> <u>Aug 30, 1959</u> and last saw her <u>alive</u> on <u>Aug 27, 1959</u> Death occurred at <u>7:55 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Lewis Littmann MD</u>		22b. ADDRESS <u>8231 Clayton Rd (17)</u>		22c. DATE SIGNED <u>8/31/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/1/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	23d. LOCATION (City, town, or county) <u>St. Louis County</u>	(State) <u>Mo.</u>

24. FUNERAL DIRECTOR <u>Cullen & Kelly 7267 Natural Bridge</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-31-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 James A. Lamm

Licensed Embalmer No. 414

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.