

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031085

FILED WS SEP 8 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2345 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Manchester</u>		Length of stay in 1b <u>10 yrs.</u>		c. CITY OR TOWN <u>Manchester</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>Pine Crest Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Pine Crest Nursing Home</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OLGA</u> Middle <u>HELDMAN</u> Last				4. DATE OF DEATH Month <u>August</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 15, 1875</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department store</u>		11. BIRTHPLACE (City and state or country) <u>Augusta, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>William C. Heldman</u>			13b. MOTHER'S MAIDEN NAME <u>Mathilde Summa</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>488-30-2784</u>		17. INFORMANT Address <u>Flora Smith, 5622 Murdock</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>Hypertensive Arterio Vasculer Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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. <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 <u>March 1959</u> to <u>8-30-59</u> and last saw her alive on <u>8-25-59</u>				Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Ellen M. Farney M.D.</u> (Degree or title)			22b. ADDRESS <u>7308 Beaudry</u>		22c. DATE SIGNED <u>8-31-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 2, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Co.</u>			
24. FUNERAL DIRECTOR <u>Shepard Funeral Home, 1167 Hamilton Ave.</u>			25. DATE RECD. BY LOCAL REG. <u>8-31-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

