

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033884

FILED VS OCT 15 1959

2 9122

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4 days	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's Hospital		d. STREET ADDRESS (If outside, give location) 3308 Winnebago	
3. NAME OF DECEASED (Type or print) First Sophie Middle C. Last Haupt		4. DATE OF DEATH Month October Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/13/1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Germany
13a. FATHER'S NAME Gottlieb Palmer		13b. MOTHER'S MAIDEN NAME Katherina Breisinger	14. NAME OF HUSBAND OR WIFE Carl Haupt
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. 495-12-5048B	17. INFORMANT Address Carl Haupt, 3308 Winnebago, St. Louis
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) recurrent ca of Pelvic & generalized calcin metast. 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 199.2
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 checked="" 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 1957 to Oct 3, 1959 and last saw her alive on Oct 3, 1959 Death occurred at 2:05 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Jos. Grand M.D.		22b. ADDRESS 5521 S. Parkway	22c. DATE SIGNED 10/5/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/6/1959	23c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchyard	23d. LOCATION (City, town or county) (State) St. Louis County, Missouri
24. FUNERAL DIRECTOR ADDRESS Hoffmeister Colonial Mortuary 6464 Chippewa St., St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. OCT 5 '59	26. REGISTRAR'S SIGNATURE Road Smith M.D.

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John L. Henne
Licensed Embalmer No. 4194
P. O. Address St.

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.