

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS SEP 29 1959**

**59-033887**  
 STATE FILE NUMBER

**2 8508**  
 Registrar's No.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in lb <b>1 month</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>Lutheran Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>3644 Russell Blvd.</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <b>Belle Heine</b>			4. DATE OF DEATH Month Day Year <b>September 13, 1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/26/1883</b>
9. AGE (last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Greenville, Illinois</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Strange Hamel</b>	
13b. MOTHER'S MAIDEN NAME <b>Vesta Lloyd</b>		14. NAME OF HUSBAND OR WIFE <b>William Heine (Deceased)</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>yes</b>	
17. INFORMANT <b>Mrs. Vesta Steinbrugge</b>		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) <b>Atherosclerosis &amp; Cerebral edema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>and Arteriosclerotic</b>			
DUE TO (c) <b>Heart Disease &amp; C Failure</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>33xx</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 checked="" 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 s.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 <b>8/13/59</b> to <b>9/12/59</b> and last saw her alive on <b>9/11/59</b>		Death occurred at <b>12:05</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Deceased or title) <b>Walter H. Hochstadt</b>		22b. ADDRESS <b>3108 S. Grand</b>	
22c. DATE SIGNED <b>9/14/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/16/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>7901 Gravois, St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Hoffmeister Colonial Mortuary</b> ADDRESS <b>6464 Chippewa Street, St. Louis, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 15 '59</b>	
26. REGISTRAR'S SIGNATURE <b>Loal Smith, 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 me

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*John P. Hennrich*

Licensed Embalmer No. 4194

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.