

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS SEP 2 9 1959

59-033899

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-8667**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 17 days	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If outside, give location) 4008 Lexington	
3. NAME OF DECEASED (Type or print) First Marie Middle J. Last Hetlage		4. DATE OF DEATH Month 9 Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/12/93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Department Store	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Henry S. Hetlage		13b. MOTHER'S MAIDEN NAME Louisa Stickford	
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. 487-32-3305	
17. INFORMANT Mr. Louis J. Hetlage		Address 10927 Riverview	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma ovary Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) 175.0			INTERVAL BETWEEN ONSET AND DEATH 8 weeks
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 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 _____ 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 Jan 19 9 9-19-59 to 9-19-59 and last saw ^{her} _{him} alive on 9-19-59 Death occurred at 9:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Carl E. Lischer M.D.		22b. ADDRESS 457 Kings Highway	
22c. DATE SIGNED 9-21-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 9/22/59	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
24. FUNERAL DIRECTOR Drehmann-Harral		ADDRESS 1905 Union	25. DATE RECD. BY LOCAL REG. SEP 21 59
26. REGISTRAR'S SIGNATURE Loan 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 Albert R. Thompson

Licensed Embalmer No. 4237

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.