

# FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 16 1959

59-034045

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>5 days</b>		c. CITY OR TOWN <b>Webster Groves</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>Jewish Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>408 Bompert</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>SADIE</b> Middle <b>LOWENHAUPT</b> Last _____				<b>4. DATE OF DEATH</b> Month <b>Aug.</b> Day <b>22</b> Year <b>1959</b>									
<b>5. SEX</b> <b>F</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9-25-1881</b>		<b>9. AGE (last birthday)</b> <b>77</b>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At home</b>				<b>11. BIRTHPLACE</b> (City and state or country) <b>Vincennes, Ind.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>			
<b>13a. FATHER'S NAME</b> <b>Dan Oestreicher</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Carrie Lyons</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Dan Lowenhaupt</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Robert Roderick, 408 Bompert</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia due to abscess.</b> 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) <b>Carcinoma metastatic Ca Breast</b>										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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.      Month, Day, Year _____				<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____ STATE _____	
<b>21. I attended the deceased from</b> <b>1946</b> to <b>8-22-59</b> and last saw her alive on <b>8-22-59</b> Death occurred at <b>6:45</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <b>Frederic B. Kerolani M.D.</b>					<b>22b. ADDRESS</b> <b>950 Franklin St.</b>			<b>22c. DATE SIGNED</b> <b>8-28-59</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b>		<b>23b. DATE</b> <b>8-24-59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Valhalla Crematory</b>			<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Co., Mo.</b>						
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Parker-Aldrich, Webster Groves</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>AUG 24 '59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Carl Smith, M.D.</b> T.P.							

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 Leslie Hesch

Licensed Embalmer No. 4395  
P. O. Address Hoboken, N.J.

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.