

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-034085

## FILED VS SEP 16 1959

STATE FILE NUMBER

 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7747**

UNDECEASED

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b> Length of stay in lb _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>ST. LOUIS</b> c. CITY OR TOWN <b>Glasgow Village</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>10518 Spring Garden Dr</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>DOROTHY</b> Middle <b>C.</b> Last <b>MEIER</b>			<b>4. DATE OF DEATH</b> Month <b>AUGUST</b> Day <b>19</b> Year <b>1959</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11-5-1880</b>	<b>9. AGE (last birthday)</b> <b>78</b>	<b>IF UNDER 1 YEAR</b> IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Linen Room</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Lutheran Hosp</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Pleasant Hill Ill</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>		
<b>13a. FATHER'S NAME</b> <b>Robert Martin</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Not Known</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Anthony</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>497-01-0888</b>	<b>17. INFORMANT</b> Address <b>10518 Spring Garden Dr</b> <b>Willard Meier</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>MYOCARDIAL INFARCTION</b> DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>420.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b> <b>10 YEARS</b>		
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			
<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"/> NOT WHILE AT WORK <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>	<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <b>AUGUST 9, 1958</b> <b>4:35 p.m.</b> <b>to</b> <b>AUGUST 19, 1959</b> <b>and last saw her/him alive on</b> <b>AUGUST 19, 1959</b> Death occurred at _____ 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>H. Bradley</b> <b>M. D.</b>			<b>22b. ADDRESS</b> <b>BARNES HOSPITAL</b>		<b>22c. DATE SIGNED</b> <b>8/19/59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	<b>23b. DATE</b> <b>8-22-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Memorial Park</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Schaumburg Ill</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>AUG 21 1959</b>			
<b>24. FUNERAL DIRECTOR</b> <b>C. Kroe</b> <b>2707 N Grand</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Paul Smith, M.D.</b>					

(Licensed Embalmer's Statement on Reverse Side)

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 Seaton W. Dieter

Licensed Embalmer No. 4329

P. O. Address Howie

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.