

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034753**

**FILED VS SEP 21 1959**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2313

1. PLACE OF DEATH a. COUNTY <u>St. Louis,</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lemay,</u>		Length of stay in 1b <u>7 months</u>	c. CITY OR TOWN <u>St. Louis,</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mt St Rose Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4921 Fernod</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>AUGUSTINE</u> Middle <u>BIRKENMEIER</u> Last			4. DATE OF DEATH Month <u>Aug.</u> Day <u>26th,</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-1888</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>New York City</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Patrick McCarthy</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Powers</u>		14. NAME OF HUSBAND OR WIFE <u>Late Charles H. Birkenmeier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT Address <u>Loretta Reuter-5033 Miami St.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>331x</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>8 mos.</u>
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 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 <u>          </u> a.m. <u>          </u> p.m. Month, Day, Year <u>          </u>		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 <u>3-19-59</u> to <u>3-26-59</u> and last saw her <u>alive</u> on <u>8-25-59</u> Death occurred at <u>1:05 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>James A. Turner MD</u>			22b. ADDRESS <u>4401 Hampton</u>		22c. DATE SIGNED <u>8-27-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug. 29, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City, town, or county) <u>St. Louis,</u>	(State) <u>Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser-4228 S. Kingshighway</u>			25. DATE RECD. BY LOCAL REG. <u>8-27-59</u>	26. REGISTRAR'S SIGNATURE <u>James A. Turner MD</u>	

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

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Sal Afham

Licensed Embalmer No. 4533

P. O. Address \_\_\_\_\_

**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.