

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED OCT 13 1959

59-034754

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2613

ENDED

|  |  |   |  |   |  |  |   |  |
|--|--|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b> |  |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Lemay</b>  |  | Length of stay in 1b<br><b>YRS</b>  |  | c. CITY OR TOWN <b>Lemay</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>907 Dammert ave.</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>907 Dammert ave.</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Helen</b> First Middle Last <b>Blank</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>30</b> Year <b>1959</b>   |  |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-4-1902</b>  | 9. AGE (last birthday)<br><b>57</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.                                  | IF UNDER 24 HR   |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis Co. Mo.</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U S A</b>  |   |  |
| 13a. FATHER'S NAME<br><b>August Braun</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Annie Gieson</b>                                     |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Thomas</b>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>499-32-7432</b>   |  | 17. INFORMANT<br><b>Thomas Blank</b>  |  | Address<br><b>907 Dammert ave, Lemay 25 Mo</b>                                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br>DUE TO (b) <b>hypertension</b><br>DUE TO (c) <b>arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>immediate</b>                                 |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>a.m. p.m.  | 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>June 1954</b> to <b>Jan 20, 1958</b> and last saw her <b>live on Jan. 20, 1958</b><br>Death occurred at <b>8 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |  |   |  |  |   |  |
| 22a. SIGNATURE <b>Robert T. Styles D.O.</b> (Degree or title)  |  |   |  | 22b. ADDRESS<br><b>631 Union Rd. Apt 23</b>   |  | 22c. DATE SIGNED<br><b>Dec 19/1959</b>   |   |  |
| 23a. REMARKS<br><b>Remove</b>  |  | 23b. DATE<br><b>Oct. 5, 1959</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Cemetery</b>                       |   | 23d. LOCATION (City, town, or county) (State)<br><b>Jefferson Bks. Mo.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>C. Hoffmeister Mortuaries</b><br><b>7814 S. Broadway</b>  |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>10-2-59</b>                                       |   | 26. REGISTRAR'S SIGNATURE<br><b>John G. Mumfley 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 S. Demme  
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.