

**JURI DIVISION: OFFICE OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034766**

**FILED VS SEP 28 1959**

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2523 STATE FILE NUMBER

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 <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>AFFTON</u>		c. CITY OR TOWN <u>AFFTON</u>	
Length of stay in lb <u>YRS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>10018 N MARLENE</u>		d. STREET ADDRESS (If outside, give location) <u>10018 N MARLENE</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ELMER</u> Middle <u>C</u> Last <u>DAVIDTER, SR.</u>			4. DATE OF DEATH Month <u>SEPT</u> Day <u>21</u> Year <u>1959</u>			
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/13/1919</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FLOOR CO.</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>

13a. FATHER'S NAME <u>FRED DAVIDTER</u>	13b. MOTHER'S MAIDEN NAME <u>IDA VASEL</u>	14. NAME OF HUSBAND OR WIFE <u>JOSEPHINE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>YES WW-II</u>	16. SOCIAL SECURITY NO. <u>489-16-8247</u>	17. INFORMANT Address <u>10018 MARLENE</u> <u>JOSEPHINE DAVIDTER N.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>2 yrs</u> <u>4 yrs.</u>
IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Insufficiency</u>	
	DUE TO (c) <u>Arteriosclerosis</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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from <u>9-21-59</u> to <u>9-21-59</u> and last saw her/him alive on <u>9-21-59</u> Death occurred at <u>12:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Eugene H. Godde M.D.</u>	22b. ADDRESS <u>4971 Cluppewa St</u>	22c. DATE SIGNED <u>9-21-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9/23/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co., Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>J L ZIEGENHEIN &amp; SONS 7027 GRAVOIS</u>	25. DATE RECD. BY LOCAL REG. <u>9-22-59</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Murphy M.D.</u>
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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 C. P. Kridwell

Licensed Embalmer No. 3877

P. O. Address 7027 Graven

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.

*[Handwritten scribbles at the bottom left of the page]*