

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 28 1959

59-037833

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 9594**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b 50 yrs		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hesp. #1			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3814 California Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Louise # Middle McDowell Last				4. DATE OF DEATH OCT. 18, 1959 Month Day Year					
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/6/1880	9. AGE (last birthday) 79 yrs	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) housework		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and state or country) St. Charles, Missouri		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Henry Ehlmann			13b. MOTHER'S MAIDEN NAME Catherine Kruse			14. NAME OF HUSBAND OR WIFE Walter R. McDowell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Walter McDowell, 3220 Keokuk Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma						INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) PRIMARY site undetermined.									
DUE TO (c) 199.2									
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			
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 Month, Day, Year 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.) 9/22/59		20f. CITY, TOWN, OR LOCATION COUNTY STATE 10/18/59			
21. I attended the deceased from _____ to _____ and last saw her him alive on 10/18/59 Death occurred at 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE W. Leightner MD (Degree or title)				22b. ADDRESS 1515 Lafayette Ave.				22c. Day 10/18/59 10/18/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE Oct. 22, 1959	23c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran Cemetery			23d. LOCATION (City, town, or county) (State) St. Charles, Missouri			
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave				25. DATE RECD. BY LOCAL REG. OCT 20 59		26. REGISTRAR'S SIGNATURE Earl Smith M.D.			

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 Homer W. Dintz

Licensed Embalmer No. 3882

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.