

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 0 1959

59-041906

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210622**

| | | | |
|---|---|---|---|
| 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 | | Length of stay in 1b 2 weeks | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 4449 West Pine Blvd Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Caroline Middle B Last Hacke | | | 4. DATE OF DEATH Month November Day 15 Year 1959 |
| 5. SEX female | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12-10-1887 |
| 9. AGE (last birthday) 71 | | 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) Seamstress - Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Ely-Walker Company | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Charles Hacke | |
| 13b. MOTHER'S MAIDEN NAME Katherine Koch | | 14. NAME OF HUSBAND OR WIFE Never Married | |
| 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. 489-16-8430 | 17. INFORMANT Address Mrs. Minet Lewton, 3920 Canterbury |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation | | | INTERVAL BETWEEN ONSET AND DEATH 3 hrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Auricular Fibrillation; Valvular Heart Disease | | | 1 yr. |
| DUE TO (c) Kypho-Scoliotic Heart Disease | | | 15 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition, given in PART I (a) Heard Old. Pulm. Tbc. | | | 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 AN 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 _____ a.m. _____ p.m. Month, Day, Year _____ | 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 1938 to Nov. 15, 1959 and last saw her ^{her} alive on Nov. 14, 1959 Death occurred at 1:00 PM on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Melvin Jess M.D. (Degree or title) | | 22b. ADDRESS 4118 3rd West Florissant Ave | 22c. DATE SIGNED 11-17-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Nov 18, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery | 23d. LOCATION (City, town, or county) St. Louis Missouri (State) |
| 24. FUNERAL DIRECTOR Math Hermann & Son, I^{nc.}, 2161 E. Fair Av ADDRESS | | 25. DATE RECD. BY LOCAL REG. NOV 18 1959 | 26. REGISTRAR'S SIGNATURE Roald 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. J. Burns

Licensed Embalmer No. 4202

P. O. Address H. Jones

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.