

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041958

FILED VS NOV 3 0 1959

210585

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>70-yrs.</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5520 Grant Place</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5520 Grant Place</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>E.</b> Last <b>Herbert</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>15,</b> Year <b>1959</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/25/89</b>		9. AGE (last birthday) <b>70</b>		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) <b>housekeeping</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Henry Lange</b>				13b. MOTHER'S MAIDEN NAME <b>Annie Doermann</b>				14. NAME OF HUSBAND OR WIFE <b>Alfred Herbert</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Mrs. Cora Steinmetz-5520 Grant Pl.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Endocarditis - coronary complication</b> <i>Endocarditis - coronary complication</i> <b>endocarditis</b> <i>endocarditis</i> DUE TO (b) <b>endocarditis</b> <i>endocarditis</i> DUE TO (c) <b>hypertension</b> <i>hypertension</i>										INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <i>4 mths</i> <b>10 years</b> <i>10 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>42.4</b>										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 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.) <b>8-28-59</b>		20f. CITY, TOWN, OR LOCATION <b>11-15-59</b>		COUNTY <b>11-14-59</b>		STATE					
21. I attended the deceased from <b>Aug 28 59</b> to <b>Nov 15 59</b> and last saw her/him alive on <b>Nov 14 59</b> Death occurred at <b>7:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Walter P. Eidmann</b> <i>Walter P. Eidmann, M.D.</i>				22b. ADDRESS <b>3146 Morganford Rd.</b> <i>3146 Morganford Rd</i>				22c. DATE SIGNED <b>11-17-59</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>Nov. 18, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>				23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Missouri</b>					
24. FUNERAL DIRECTOR <b>WACKER-HELDERLE-3634 Gravois Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 17 1959</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <i>EMS</i>							

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 Philip J. Karpis

Licensed Embalmer No. 3497

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.