

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042373

FILED VS DEC 7 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9856**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		a. STATE Mo.	b. COUNTY St. Louis
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospital		c. CITY OR TOWN Jennings	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Length of stay in lb 4 weeks		d. STREET ADDRESS 5472 Jennings Rd.	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Myrtle	Middle	Last Postle	4. DATE OF DEATH	Month Oct.	Day 25	Year 1959
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5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1902	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) Ironwood Mich.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Albert Fredrickspn	13b. MOTHER'S MAIDEN NAME Clara Wicklund	14. NAME OF HUSBAND OR WIFE William Postle
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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. 498-12-8752	17. INFORMANT William Postle	Address 5472 Jennings Rd.
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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
IMMEDIATE CAUSE (a) Acute Congestive Heart failure		4 days
DUE TO (b) Hypertensive & arteriosclerotic Cardiovascular Disease		years
DUE TO (c) 443x		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Recent Cerebrovascular Occlusion	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
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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 _____ a.m. _____ p.m. _____	Month, Day, Year
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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
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21. I attended the deceased from 4/8/57 to 10/25/59 and last saw her alive on 10/24/59
Death occurred at 2AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert A. Bauer M.D.	(Degree or title)	22b. ADDRESS 3731 Goodfellow	22c. DATE SIGNED 10/27/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 10-28-1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Buchholz Mort. 5967 W. Florissant Av.	ADDRESS	25. DATE RECD. BY LOCAL REG. OCT 27 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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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

U E Morris

Licensed Embalmer No. 3360

P. O. Address A Lane

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.