

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002228

FILED VS JAN 11 1960

STATE FILE NUMBER

Registration District No. 159 Primary Registration District No. 4249 Registrar's No. 97

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| 1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HILLSBORO</u> | | c. CITY OR TOWN <u>ST. LOUIS</u> | |
| Length of stay in 1b <u>3 YEARS</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>CEDAR GROVE NURSING HOME</u> | | d. STREET ADDRESS (If outside, give location) <u>2838 MICHIGAN</u> | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|----------------------------------|---|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>METZGER</u> Last | | | 4. DATE OF DEATH Month <u>JAN</u> Day <u>3</u> Year <u>1960</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-25-1873</u> | 9. AGE (last birthday) <u>86</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>MISSOURI</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
| 13a. FATHER'S NAME <u>BERNARD SCHUMACHER</u> | | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>GUSTAVE METZGER (DEED)</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>WILFRED BERNARD</u> Address <u>ROUTE 9 O'FALLON, MO</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: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | |

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| 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 | |
|---|--|--|--|

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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.) | |
| 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 Dec. 13, 1956 to Jan. 3, 1960 and last saw her from alive on Jan. 2, 1960
Death occurred at 8:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|---------------------------------|--|---|-----------------------------------|
| 22a. SIGNATURE <u>Robert D. Sanders M.D.</u> (Degree or title) | | 22b. ADDRESS <u>1502 Cass Ave. - St. Louis</u> | | 22c. DATE SIGNED <u>1-4-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>JAN 5, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>S.S. PETER E PAUL CEM</u> | 23d. LOCATION (City, town, or county) <u>ST. LOUIS</u> | (State) <u>Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Thomas Luta</u> ADDRESS <u>2906 Gravois</u> | | 25. DATE RECD. BY LOCAL REG. <u>1-4-60</u> | 26. REGISTRAR'S SIGNATURE <u>Alta Richards, Jr.</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 2 1958

JAN 22 1958

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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.