

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002984

FILED VS FEB 11 1960

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 28

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST. CHARLES</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. CHARLES</u>		Length of stay in 1b <u>89 YRS</u>		c. CITY OR TOWN <u>ST CHARLES</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>237N.KINGSHIGHWAY</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>237N.KINGSHIGHWAY</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THERESA</u> Middle <u>M.</u> Last <u>AMPTMANN</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>29</u> Year <u>1960</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>JULY 15, 1870</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
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 <u>IN OWN HOME</u>		11. BIRTHPLACE (City and state or country) <u>PORTAGE DES SIOUX, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>FRANK DRILLER</u>			13b. MOTHER'S MAIDEN NAME <u>MARY C.</u>			14. NAME OF HUSBAND OR WIFE <u>EDWARD AMPTMANN. DECEASED 1956</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>VIOLA AMPTMANN, ST. CHARLES, Mo</u> Address <u></u>			
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>Hypertensive Cardiovascular disease</u> DUE TO (b) <u>disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>acute pulmonary congestion</u>							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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>						
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 <u>Nov 1950</u> to <u>Jan 4-60</u> and last saw her alive on <u>Jan 15-60</u> Death occurred at <u>8:30 AM</u> on <u></u> the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Vincent A Schneider MD.</u>				22b. ADDRESS <u>St Charles Mo</u>			22c. DATE SIGNED <u>2-1-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>FEB. 1, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CATH. CEM.</u>		23d. LOCATION (City, town, or county) <u>ST. CHARLES, Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>C.L. PRINSTER, ST. CHARLES, Mo</u> ADDRESS <u></u>				DATE RECD. BY LOCAL REG. <u>Feb. 1-60</u>		26. REGISTRAR'S SIGNATURE <u>Maurella Wilson</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

PRINSTER-HUGHES F.H., INC.

(Licensed Embalmer's Statement on Reverse Side)

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 Howard O. Kenler

Licensed Embalmer No. 4631

P. O. Address Wentzville

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.