

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-004536

FILED VS. FEB 15 1960 317

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 422

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>ST. CHARLES</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORMANDY</u>		Length of stay in lb <u>2 1/2 mos</u>		c. CITY OR TOWN <u>ST. CHARLES</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
c. FULL NAME OF (IF NOT IN HOSPITAL, give location) HOSPITAL OR INSTITUTION <u>O'SULLIVAN NURSING HOME</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>R.R.#1</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>ALBERTA</u> Middle <u>-</u> Last <u>BIERDEMAN</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>8</u> Year <u>1960</u>											
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUCASIAN</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>6-8-1874</u>		9. AGE (last birthday) <u>85</u>		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) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>				11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>UNKNOWN</u>				13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				14. NAME OF HUSBAND OR WIFE <u>DECEASED</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 Address <u>CHARLES BIERDEMAN, ST. CHARLES, MO</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>Complete heart block</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)								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. _____		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>Dec 3, 1959</u> to <u>Feb 8, 1960</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>Feb 8, 1960</u> Death occurred at <u>7:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.															
22. SIGNATURE <u>Lewis Littmann</u> (Degree or title)				22a. ADDRESS <u>8231 Clayton Rd (17)</u>				22c. DATE SIGNED <u>2-9-60</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>2-10-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA</u>				23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO., MO.</u>							
24. FUNERAL DIRECTOR <u>ROSE PRINSTER, ST. CHARLES, MO</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2-9-60</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

C.L.

**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. REMAINS NOT EMBALMED —

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.