URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 3 1960

60-009422
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 650

1. PLACE OF DEATH
a. COUNTY: St Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: OAKVILLE — Length of stay in 1b: 6 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 234 Cliff Cave Rd — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St Louis
c. CITY OR TOWN: OAKVILLE — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 234 Cliff Cave Rd — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: ERNESTINE Middle: Last: VON TALGE

4. DATE OF DEATH: Month: FEB Day: 23 Year: 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: JUNE 28 1878
9. AGE (last birthday): 81
IF UNDER 1 YEAR: Months 7 Days 26 — IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (City and state or country): St Louis Co, Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: WILHELM MEIER
13b. MOTHER'S MAIDEN NAME: KATHERINE RAUSCHER
14. NAME OF HUSBAND ~~OR WIFE~~ (DECEASED): SAMUEL VON TALGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: EDNA HASSLER Address: 234 Cliff Cave Rd St Louis 29 Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage left femoral artery
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Lymphosarcoma left inguinal area — INTERVAL BETWEEN ONSET AND DEATH: few years
DUE TO (c):
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. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Feb. 1, 1959, to Feb. 20, 1960 and last saw her ~~him~~ alive on Feb. 20, 1960
Death occurred at 4 am Feb-23-1960 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Albert M. Styles, D.O
22b. ADDRESS: 631 Union Rd. Affton 23 Mo
22c. DATE SIGNED: 2/25/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: FEB-26-1960
23c. NAME OF CEMETERY ~~OR CREMATORY~~: OLD St JOHNS Cem.
23d. LOCATION (City, town, or county) (State): MEHLVILLE Mo.
24. FUNERAL DIRECTOR ADDRESS: FEY FUNERAL HOME MEHLVILLE, Mo
25. DATE RECD. BY LOCAL REG.: 2-26-60
26. REGISTRAR'S SIGNATURE: Jno. C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 Gustav W Siete

Licensed Embalmer No. 432

P. O. Address St Louis

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