

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012714

FILED VS APR 4 1960

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-3358**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b 39 yrs.		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1208 No. 8th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MRS. AMY Middle B. Last HIMMEGER				4. DATE OF DEATH Month March Day 21 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1882	9. AGE (last birthday) 77	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) Saleslady (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Famous-Barr Co.		11. BIRTHPLACE (City and state or country) West Mansfield, Ohio		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Franklin Nelson Benedict			13b. MOTHER'S MAIDEN NAME Clara Grant		14. NAME OF HUSBAND OR WIFE John W. Himmeger		
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. 493-03-6132		17. INFORMANT Address Mr. G.E. Himmeger 3514 Bel-Aire Pl.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION						INTERVAL BETWEEN ONSET AND DEATH 2-3 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE						10 YEARS.	
DUE TO (c) 420.0							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PULMONARY EMBOLUS.					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 checked="" type="checkbox"/> NO <input 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 FEB 22, 1960 to MAR 21, 1960 and last saw her ^{her} _{him} alive on MAR 21, 1960 . Death occurred at 7:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>David Pedman M.D.</i>				22b. ADDRESS 1507 N. Meramec Clayton 5		22c. DATE SIGNED 3/24/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/25/1960	23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons 6175 Delmar Blvd.		25. DATE RECD. BY LOCAL REG. MAR 24 1960		26. REGISTRAR'S SIGNATURE <i>Loel Smith M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. David Feldman

150 No. Meramec

PA6-2611 Hrs. Thurs. 9 = 1:30

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 Joseph E. McCulloch

Licensed Embalmer No. 276

P. O. Address 6176 Pl

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.