

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013195

FILED VS MAR 24 1960

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STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>			Length of stay in 1b <u>D.O.A.</u>		c. CITY OR TOWN <u>St. Louis</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>City Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1229 Gimblin</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>H</u> Last <u>SEGELKEN</u>				4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/9/82</u>	9. AGE (last birthday) <u>77</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>Special Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Post Office</u>		11. BIRTHPLACE (City and state or country) <u>Germany</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13a. FATHER'S NAME <u>Ahrendt Segelken</u>				
13b. MOTHER'S MAIDEN NAME <u>Anna (Unknown)</u>			14. NAME OF HUSBAND OR WIFE <u>Adela Kuhlmann (dec.)</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>Herbert Segelken 770 Clark (Florissant)</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>Cerebral Hemorrhage</u> DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>331x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
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		
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 Month, Day, Year 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 _____ to _____ and last saw her/him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <u>Herbert Segelken</u>			22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>3-1-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>March 2, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Bethlehem Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>			
24. FUNERAL DIRECTOR <u>BEIDERWIEDEN F.H.INC. 1936 St. Louis Av.</u>			25. DATE RECD. BY LOCAL REG. <u>MAR 1 1960</u>		26. REGISTRAR'S SIGNATURE <u>Heart Smith, M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

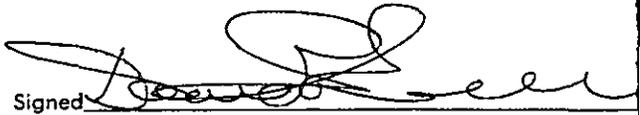
BY APPROVAL OF

2186

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 

Licensed Embalmer No. 4520

P. O. Address Alam

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