

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025413

FILED VS JUN 20 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1685 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>CHESTERFIELD, MO. RT1</u>	Length of stay in 1b <u>LIFE</u>	c. CITY OR TOWN <u>CHESTERFIELD, MO. RT1</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>Schoettler Road</u>		d. STREET ADDRESS (If outside, give location) <u>SCHOETTLE R.D.</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>EMIL</u> Last <u>Mertz</u>			4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/1885</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </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>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own FARM</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis Co., Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>GEORGE MERTZ</u>		13b. MOTHER'S MAIDEN NAME <u>LOUISA SCHOETTLE R</u>		14. NAME OF HUSBAND OR WIFE <u> </u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>George Mertz, Chesterfield, Mo. Rt 1</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>CEREBRAL HEMORRHAGE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>AT LEAST 7 YRS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>HYPERTENSIVE, ARTERIO-SCLEROTIC CEREBRO-VASCULAR DISEASE</u>	
DUE TO (c) <u> </u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>		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.) <u> </u>	
20c. TIME OF INJURY Hour <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.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u>JUNE 1953</u> to <u>MAY 20 1960</u> and last saw her/him alive on <u>MAY 20 1960</u> Death occurred at <u>6:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>James E. Meyer, M.D.</u>		22b. ADDRESS <u>BALLWIN, MO.</u>		22c. DATE SIGNED <u>MAY 28 1960</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/30/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>MANCHESTER MO.</u>	
24. FUNERAL DIRECTOR <u>SCHRADER, BALLWIN, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-28-60</u>	REGISTRAR'S SIGNATURE <u>James E. Meyer, M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Richard Bopp

Licensed Embalmer No.

4584

P. O. Address

Bullwin

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.