

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

-60-029179

FILED VS JUL 22 1960

317

Primary Registration District No. 590

Registrar's No. 2013

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>County of St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Pine Lawn</b>	Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Pine Lawn</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Res. 6602 Hazen</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6602 Hazen</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <b>MR. EDWARD DAVID HERHOLD</b>			4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1960</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/1887</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, or retired) <b>Salesman Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Magic Chef Store</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Henry Herhold</b>	13b. MOTHER'S MAIDEN NAME <b>Lillie Veyrasat</b>	14. NAME OF HUSBAND OR WIFE <b>Mary Fowler Herhold</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. E.D. Herhold 6602 Hazen (20)</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
DUE TO (b) <b>CEREBRAL ARTERIO SCLEROSIS</b>		
DUE TO (c) <b>OK. Colony 12/71</b>		
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 **called to pronounce** to **PATIENT DEAD** and last saw him alive on **14/5** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Frank Cohen M.D.</b>	22b. ADDRESS <b>708rv St Charles Road - ST ANN MO</b>	22c. DATE SIGNED <b>7/1/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7/5/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Galvary Cemetery</b>
		23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>

24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>7-5-60</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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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 Joe S. McCulloch

Licensed Embalmer No. 2760

P. O. Address 614 1/2 St.

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.