

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

FILED VS SEP 2 1960 **318**

**1003**

**-60-032740**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **7818**

**7818**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b	c. CITY OR TOWN <b>Sappington</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>#2 Cloverly Lane</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>CHARLES A POSTEL</b>			4. DATE OF DEATH <b>AUGUST 6 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>9-8-86</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee of Union Biscuit Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Biscuit Co.</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>Jacob Postel</b>		13b. MOTHER'S MAIDEN NAME <b>Frieda Vogt</b>		14. NAME OF HUSBAND OR WIFE <b>Minnie Postel</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Minnie Postel #2 Cloverly Lane</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>RIGHT PLEURAL EFFUSION</b>		<b>2 DAYS</b>
DUE TO (b) <b>CONGESTIVE HEART FAILURE</b>		<b>10 YEARS</b>
DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		<b>10 YEARS</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>MUCOCELE OF GALLBLADDER</b>		420.0	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown
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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.)
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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
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21. I attended the deceased from <b>JUNE 1943</b> to <b>AUGUST 6, 1960</b> and last saw her/him alive on <b>AUGUST 6, 1960</b> Death occurred at <b>12:15 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>C. J. Hamilton, M.D.</i>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>8/8/60</b>
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23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-9-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>
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24. FUNERAL DIRECTOR <b>Kriegshauser</b>	ADDRESS <b>4228 S. Kingshighway Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 8 1960</b>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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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 R. W. Stovessand

Licensed Embalmer No. 4007

P. O. Address \_\_\_\_\_

**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.