

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033196

FILED VS SEP 7 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2463 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>Clayton</u>		Length of stay in 1b <u>4 da.</u>	c. CITY OR TOWN <u>St. Johns</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>St. Louis Co. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3524 Marshall</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>M.</u> Last <u>Hebold</u>			4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>Fem,</u>	6. COLOR OR RACE <u>White</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>11/23/49</u>	9. AGE (last birthday) <u>10</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>Walter Hebold</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Duke</u>		14. NAME OF HUSBAND OR WIFE	
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.		17. INFORMANT <u>Walter Hebold</u> Address <u>3524 Marshall</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>Bilateral pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
DUE TO (b) <u>Agranulocytosis</u>			
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Gen. Lymphadenopathy</u>		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	
--	--	--	--

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 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 <u>St. Louis</u>	COUNTY <u>St. Louis</u>	STATE <u>Mo.</u>
--	--	--	----------------------------	---------------------

21. I attended the deceased from 8-14-60 to 8-16-60 and last saw her him alive on 8-16-60
Death occurred at 6:35 A. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Albert L. Howe M.D.</u> (Degree or title)		22b. ADDRESS <u>601 S. Brentwood Clayton 5 Mo</u>		22c. DATE SIGNED <u>8-16-60</u>
--	--	--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/19/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u> (State)
--	-----------------------------	---	--

24. FUNERAL DIRECTOR <u>Ortmann F Home</u> ADDRESS <u>9222 Lackland</u>		25. DATE RECD. BY LOCAL REG. <u>8-18-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy Md.</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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Al C Ostermann

Licensed Embalmer No. 3478

P. O. Address _____

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.