

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033197

FILED VS SEP 7 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2296 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Clayton</b>		Length of stay in 1b <b>D.O.A.</b>		c. CITY OR TOWN <b>Pagedale</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>St. Louis County Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1262 Kingsland</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sophie</b> Middle <b>W.</b> Last <b>Heck</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1960</b>				
5. SEX <b>female</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>1-6-15</b>	9. AGE (last birthday) <b>45</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Matron</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DeSmet School</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Paul Obremski</b>			13b. MOTHER'S MAIDEN NAME <b>Nora Kaczinski</b>		14. NAME OF HUSBAND OR WIFE <b>Arthur C. Heck</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>488-10-6728</b>		17. INFORMANT Address <b>Mr. Arthur C. Heck, 1262 Kingsland</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 HEMORRHAGE</b> <b>11)</b> <b>GENERALIZED ORGAN CONGESTION</b> DUE TO (b) <b>MINIMAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>MASSIVE CEREBRAL HEMORRHAGE WITH INTERVENTRICULAR</b> EXTENSION							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the toxicologic condition given in PART I (a) <b>MARKED HERNIATION OF CEREBELLAR TONSILS - SLIGHT BASILAR SUBARACHNOID HEMORRHAGE</b>							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 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 _____ 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	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>8:28 pm.</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>C. Howe Miller, M.D., Commissioner of Health</b>				22b. ADDRESS <b>801 South Brentwood</b>		22c. DATE SIGNED		
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-2-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethany Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri.</b>			
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc. 2161 E. Fair</b>				ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9-7-60</b>	26. REGISTRAR'S SIGNATURE <b>Hustard Miller M.</b>		

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 *Wesley H. Nash*  
\_\_\_\_\_

Licensed Embalmer No. 3737

P. O. Address St. Louis

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.