

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-036882

FILED VS. SEP 19 1960

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 2695 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ferguson, Mo.		Length of stay in lb 3 years	c. CITY OR TOWN Ferguson Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Oak Knoll Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 37 North Clark St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Katherine Middle B. Last Heidenreich			4. DATE OF DEATH Month September Day 10, Year 1960.		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-2-1896	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
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) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John Heidenreich		13b. MOTHER'S MAIDEN NAME Mary Alles		14. NAME OF HUSBAND OR WIFE Single	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	17. INFORMANT Address Greensburg, Ind. Mrs Marie Springer, 309 So. Broadway
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH stat
DUPLICATE TO (b) Arteriosclerotic Cerebro-		
DUPLICATE TO (c) vascular disease		unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Idiopathic epilepsy		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ 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
21. I attended the deceased from June 26, 1957 , to Sept 10, 1960 and last saw her ^{him} alive on 9/6/60 Death occurred at 6:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) Lewis Littmann MD	22b. ADDRESS 8231 Clayton Rd (17)	22c. DATE SIGNED 9/12/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-13-1960	23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery
24. FUNERAL DIRECTOR ADDRESS Math. Hermann & Son Inc., 2161 E. Fair Ave.		23d. LOCATION (City, town, or county) St. Louis, Missouri.

25. DATE RECD. BY LOCAL REG. 9-12-60	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Allen W. Noy

Licensed Embalmer No. 375

P. O. Address H. Lane

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.