

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036917

FILED VS. SEP 19 1960

317

Registration District No. 547

Registrar's No. 2597

STATE FILE NUMBER

INDEXED

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) OR TOWN <b>Richmond Heights</b>		Length of stay in lb <b>1 week</b>		c. CITY OR TOWN <b>Sycamore Hills</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. Marys Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>8900 Sycamore Court</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Haberstroh</b> Last				4. DATE OF DEATH Month <b>Sept.</b> Day <b>2</b> Year <b>1960</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-14-89</b>		9. AGE (last birthday) <b>71</b>		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) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</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>Paul Schwartzkopf</b>				13b. MOTHER'S MAIDEN NAME <b>Laura Pickering</b>				14. NAME OF HUSBAND OR WIFE <b>Charles Dcd.</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 <b>Martin P. Haberstroh</b>		Address <b>8900 Sycamore</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>Arteriosclerotic heart disease</b> DUE TO (b) <b>Diabetes mellitus</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>3 yrs.</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 checked="" 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 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 <b>4-12-46</b> to <b>9-2-60</b> and last saw her <sup>her</sup> <sub>alive</sub> on <b>9-2-60</b> . Death occurred at <b>2:30P</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>James P. Murphy</b> (Degree or title)				22b. ADDRESS <b>634 N. Grand</b>				22c. DATE SIGNED <b>9-3-60</b>					
23a. BURIAL - CREMATION <b>REBURIAL</b>		23b. DATE <b>9-6-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>					
24. FUNERAL DIRECTOR <b>Stumann Bros. Inc.</b> 2504 Woodson Rd - Overland - 14 - Mo.				25. DATE RECD. BY LOCAL REG. <b>9-3-60</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</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 David C. Gibb

Licensed Embalmer No. 3454  
P. O. Address Overland

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.