

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040591

FILED VS NOV 9 1960 317 Registration District No. Primary Registration District No. 300 Registrar's No. 3099 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 Normandy		Length of stay in 1b 2 Days	c. CITY OR TOWN Page Dale Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Hosp. Normandy Osteopathic		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1516 Purdue Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MRS EMMA Middle ORDELHEIDE Last ORDELHEIDE			4. DATE OF DEATH Month October Day 23 Year 1960			
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5. SEX F.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/12/1897	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St. Louis Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Stoye	13b. MOTHER'S MAIDEN NAME Louisa Schultz	14. NAME OF HUSBAND OR WIFE Wilbert H. Ordelleide
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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. None	17. INFORMANT Address Wilbert H. Ordelleide 1516 Purdue
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Decompensated Cor Pulmonale		Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Pulmonary Carcinoma	Weeks
	DUE TO (c) Infiltrating ductal carcinoma of breast	Years
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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 **Feb. 20, 1959** to **Oct 23, 1960** and last saw her/him alive on **Oct. 22, 1960**
Death occurred at **5:40** A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert E. Owen D.O.	22b. ADDRESS 7587A Olive, St Louis 30, Mo.	22c. DATE SIGNED 10-24-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/26/1960	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. 10-26-60	26. REGISTRAR'S SIGNATURE John B. Murphy M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Dr. Robert Owen
525 St. Francis St.
7587a Olive St.
after 10 AM, 19

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 Joseph M. Cullot
Licensed Embalmer No. 245

P. O. Address 6138

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.