URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-043670

FILED VS DEC 2 1960 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11443 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b: 40 yrs

c. CITY OR TOWN St. Louis — Inside Limits: Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Anthony Hospital — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 5450 Itaska Street — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First DORA — Middle — Last HAXEL

4. DATE OF DEATH: Month Nov. Day 27, Year 1960

5. SEX: female

6. COLOR OR RACE: white

7. Married ☐ Widowed ☐ Never Married ☒ Divorced ☐

8. DATE OF BIRTH: 2/23/1893

9. AGE (last birthday): 67 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): milliner

10b. KIND OF BUSINESS OR INDUSTRY: millinery

11. BIRTHPLACE (City and state or country): Quincy, Illinois

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: William Phillip Haxel

13b. MOTHER'S MAIDEN NAME: Kate Schnellbecker

14. NAME OF HUSBAND OR WIFE: none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: 494-09-3263

17. INFORMANT — Address: Mr. Henry Haxel, 5450 Itaska Street (9)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hemorrhage, gastrointestinal — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Gastric ulcer — 1 yr.

DUE TO (c): 540.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): arteriosclerotic Heart Disease

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 1958, to 1960 and last saw her ~~him~~ alive on 11-27-60

Death occurred at 2:25 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John J. Inkley MD

22b. ADDRESS: 5203 Chippewa

22c. DATE SIGNED: 11-28-60

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 11/30/60

23c. NAME OF CEMETERY OR CREMATORY: Greenmount

23d. LOCATION (City, town, or county) (State): Quincy, Illinois

24. FUNERAL DIRECTOR — ADDRESS: BEIDERWIEDEN F.H.INC., 1936 St.Louis Ave.

25. DATE RECD. BY LOCAL REG.: NOV 28 1960

26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

Dr. John J. Inkley
[redacted] Center
1-4 PM ex. Thurs.
5201 — [illegible]

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 Homer H. Deit

Licensed Embalmer No. 388

P. O. Address St. Fra

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