

RT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043672

FILED VS DEC 7 1960

318

Primary Registration District No. 1003

Registrar's No. 11472

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MO.</i>		Length of stay in 1b <i>13 DAYS</i>		c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSP. #1</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>3127 hooe st</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>CHRISTINE</i> Middle <i>HEIDER</i> Last <i>INK</i>				4. DATE OF DEATH Month <i>II</i> Day <i>26</i> Year <i>1960</i>					
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>8/16/1876</i>	9. AGE (last birthday) <i>84</i>		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) <i>HOUSEWORK</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>GENERAL</i>		11. BIRTHPLACE (City and state or country) <i>ROSEBUD, MO</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13a. FATHER'S NAME <i>WM. HEIDBRINK</i>			13b. MOTHER'S MAIDEN NAME <i>FREDERICKA MEYER</i>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or upknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>497-03-3183A</i>		17. INFORMANT <i>Nan Meyer, 4923 Canton St. Louis, Mo</i>			Address	
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) <i>Congestive Heart Failure</i>									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									
DUE TO (b) <i>Arteriosclerotic Heart Disease</i>									
DUE TO (c) <i>420-0</i>									
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.)					
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 <i>II/13/60</i> to <i>II/26/60</i> and last saw her/him alive on <i>II/26/60</i>				Death occurred at <i>9:45 pm</i> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Francis Curry M.D.</i> (Degree or title)				22b. ADDRESS <i>1515 LAFAYETTE AVE.</i>			22c. DATE SIGNED <i>II/26/60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)				
<i>EMERALD</i>	<i>11-30-60</i>	<i>ST. JOHN HUTN. CEM.</i>			<i>DRAKE, MO.</i>				
24. FUNERAL DIRECTOR <i>SCHRAMER, BALLWIN, MO.</i> ADDRESS				25. DATE RECD. BY LOCAL REG. <i>NOV 29 1960</i>		26. REGISTRAR'S SIGNATURE <i>Leon Smith, M.D.</i>			

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 Richard Bopp

Licensed Embalmer No. 458

P. O. Address Dallwin

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.