

1. PLACE OF DEATH a. COUNTY <b>Mo</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis Mo</b>		Length of stay in 1b <b>2-weeks</b>	c. CITY OR TOWN <b>Richmond Heights Mo</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutherane Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1120 Moorlands Dr (17)</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Johanna</b> Middle Last <b>Pieper</b>			4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>60</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-26-1889</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Wife</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>Joel Louis Musick</b>		13b. MOTHER'S MAIDEN NAME <b>Ann Cavanaugh</b>		14. NAME OF HUSBAND OR WIFE <b>Ferd C. Pieper</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Ferd C. Pieper</b>	Address <b>1120 Moorlands Dr</b>
--	--	--	-------------------------------------

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 <b>15 days</b>
IMMEDIATE CAUSE (a) <b>Myocardial Infarction due</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Corony artery thrombosis</b>		
	DUE TO (c) <b>Arterio sclerotic heart disease</b>		<b>1 mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>			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 <b>St Louis Mo</b>	COUNTY <b>St Louis</b>	STATE <b>Mo</b>
--	--	--	---------------------------	--------------------

21. I attended the deceased from **Aug 6, 1959** to **Nov 11, 1960** and last saw her **live on Nov 10, 1960**  
 Death occurred at **3:15 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Edward W. Eysenbach M.D.</b>	22b. ADDRESS <b>3701 E. Grand St</b>	22c. DATE SIGNED <b>11/11/60</b>
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-14-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St Louis Mo</b>
--	--------------------------------	---	---

24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b>	ADDRESS <b>3840 Lindell Blvd</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 11 1960</b>	26. REGISTRAR'S SIGNATURE <b>Karl Smith 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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Francis William

Licensed Embalmer No. 356

P. O. Address 3840

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.