

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 25 1961

318

Primary Registration District No.

1003

Registrar's No.

493-61-002804

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b 2 Days		c. CITY OR TOWN Pine Lawn		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 4300 Dardenne Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Sophia M. Balkenbusch				4. DATE OF DEATH Month Day Year 1 16 1961			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/20/87	9. AGE (last birthday) 73	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) Machine Operator (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Small Arms		11. BIRTHPLACE (City and state or country) Osage Bend, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Joseph Hoelscher			13b. MOTHER'S MAIDEN NAME Rose Deneff		14. NAME OF HUSBAND OR WIFE August J. Balkenbusch		
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.		17. INFORMANT Address 4300 Aug. J. Balkenbusch, Dardenne		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>420.1</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Right Lower Lobe Pneumonia</i>					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 e.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>5/19/54</i> to <i>1/16/61</i> and last saw her alive on <i>1/16/61</i> Death occurred at <i>9:20 P.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Robert A Bauer M.D.</i>				22b. ADDRESS <i>3731 Goodfellow</i>		22c. DATE SIGNED <i>1/17/61</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE <i>1/19/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>		23d. LOCATION (City, town, or county) <i>St. Louis</i>		23e. STATE <i>Mo. 11</i>	
24. FUNERAL DIRECTOR <i>Drehmann-Harral, 1905 Union Blvd.</i>				25. DATE RECD. BY LOCAL REG. <i>JAN 17 1961</i>		26. REGISTRAR'S SIGNATURE <i>Loan Smith M.D.</i>	

Dr. Robert Bauer
3731 Goodfellow
Co 1-7302
Hrs.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address _____

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.