

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH															
FILED VS FEB 1 1961															
Registration District No. <u>318</u> Primary Registration District No. <u>1003</u> Registrar's No. <u>69761-008109</u>															
AMENDED 61-3163															
DATE AMENDED	1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)								
	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>						Length of stay in lb <u>1 day</u>			c. CITY OR TOWN <u>Jennings</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
INSTEAD OF	c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>						Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			d. STREET ADDRESS <u>7032 Garesche Ave.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
	3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE FRANCES HASEMEIER</u>						4. DATE OF DEATH Month Day Year <u>January 22, 1961</u>								
DOCUMENT	5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/9/1927</u>		9. AGE (last birthday) <u>33 yrs.</u>		IF UNDER 1 YEAR Months Days <u>1 13</u>		IF UNDER 24 HR Hours Min. <u>13</u>		
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>						
BY AFFIDAVIT OF	13a. FATHER'S NAME <u>William W. Endejan</u>				13b. MOTHER'S MAIDEN NAME <u>Charlotte Nancel</u>				14. NAME OF HUSBAND OR WIFE <u>James Lee Hasemeier</u>						
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>James L. Hasemeier - 7032 Garesche</u>						
SHOULD READ	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u>											INTERVAL BETWEEN ONSET AND DEATH <u>1 hrs</u>			
	Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Shock</u>											<u>3 hrs</u>			
MEDICAL CERTIFICATION	DUE TO (c) <u>Abruption Placenta</u>											<u>8 hrs</u>			
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>644x</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
SHOULD READ	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				
BY AFFIDAVIT OF	21. I attended the deceased from <u>12/29/60</u> to <u>1/22/61</u> and last saw her alive on <u>1/22/61</u> Death occurred at <u>8:25 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.														
	22a. SIGNATURE (Degree or title) <u>Hugh R. Smith M.D.</u>						22b. ADDRESS <u>100 N. Euclid</u>			22c. DATE SIGNED <u>1-22-61</u>					
BY AFFIDAVIT OF	23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Jan. 25, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co., Missouri</u>		(State)						
	24. FUNERAL DIRECTOR <u>Gebken Sons - 2630 Gravois</u>				25. DATE RECD. BY LOCAL REG. <u>JAN 23 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loed Smith M.D.</u>								

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

Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St. Louis, Mo.

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.