

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-010262

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 57

STATE FILE NUMBER

FILED VS MAR 16 1961

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>	Length of stay in 1b <u>31 Yrs.</u>	c. CITY OR TOWN <u>St. Charles</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>228 Morgan St.</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>228 Morgan St.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>J.</u> Last <u>Eriscoe</u>	4. DATE OF DEATH Month <u>Mar.</u> Day <u>2</u> Year <u>1961</u>
--	---

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>Mar. 10, 1873</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>22</u>	IF UNDER 24 HR Hours <u></u> Min. <u></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>
--	---	--	---

13a. FATHER'S NAME <u>Julius Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Schmiedeke</u>	14. NAME OF HUSBAND OR WIFE <u>William M.R. Eriscoe</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. <u>None</u>	17. INFORMANT Address <u>Mo. Mr. William Eriscoe, St. Charles,</u>
--	-------------------------------------	--

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)	<u>Myocardial Infarction</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Heart Disease 20yr</u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Herpes Zoster</u>	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 <u></u> Month, Day, Year <u></u>	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 1/52 to 1961 and last saw her alive on Mar 2, 1961
Death occurred at p on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W H Roggemeyer MD</u>	22b. ADDRESS <u>St Charles Mo</u>	22c. DATE SIGNED <u>Mar 6, 1961</u>
---	-----------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 6, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Portage des Sioux, Mo.</u>
---	-------------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>H.C. Dallmeyer & Sons, St. Charles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>March 6, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>
---	---	--

DATE AMENDED

INSTEAD OF DOCUMENT

BY AFFIDAVIT OF SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF SHOULD READ

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 _____

Licensed Embalmer No. _____

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.