

AMENDED

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 16 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) 3832 Lawler Drive		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Viola Nelson Blankenmeister				4. DATE OF DEATH Month Day Year 3 10 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 3/26/03	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Axel Nelson			13b. MOTHER'S MAIDEN NAME Marie Schieberl		14. NAME OF HUSBAND OR WIFE Harold Blankenmeister		
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. None	17. INFORMANT Address 3832 Harold Blankenmeister, Lawler Dr.				
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>Cerebral Embolism</i> DUE TO (b) <i>Myocardial Stenosis</i> DUE TO (c) <i>Old Rheumatic Heart Disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>16 days</i> <i>year</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes Mellitus</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 checked="" type="checkbox"/> NO <input 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.) <i>410X</i>			
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.) <i>12/10/56</i>		20f. CITY, TOWN, OR LOCATION <i>3/10/61</i>		COUNTY	STATE
21. I attended the deceased from <i>12/10/56</i> to <i>3/10/61</i> and last saw her alive on <i>3/9/61</i> Death occurred at <i>9:06 A</i> m 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 MD</i>			22b. ADDRESS <i>3731 Goodfellow</i>		22c. DATE SIGNED <i>3/13/61</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>3-14-1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Valhalla Cemetery</i>		23d. LOCATION (City, town, or county) <i>St. Louis County Mo.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Drehmann-Harral, 1905 Union Blvd.</i>			25. DATE RECD. BY LOCAL REG. <i>MAR 13 1961</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

Dr. Robert Bauer
3731 Goodfellow
Co 1-7302
Hrs. 1-3 1/2 Ave. 7110

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 Albert D. Thompson

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.