

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019699

FILED MAY 25 1961

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 1272

STATE FILE NUMBER

AMENDED

| | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St. Louis</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u> | | Length of stay in 1b <u>1 1/2</u> hours | | c. CITY OR TOWN <u>St. Louis 12</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>Normandy Extra. Hosp.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>58 22nd West minute</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>L.</u> Last <u>BURMEISTER</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1961</u> | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>W</u> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 11, 1889</u> | | 9. AGE (last birthday) <u>71 (-)</u> | | 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) <u>Packer Home wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hostess Bakery Co</u> | | 11. BIRTHPLACE (City and state or country) <u>Lima, Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | |
| 13a. FATHER'S NAME <u>Heinrich Schwander</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Caroline Amelung</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Martin</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> | | | | 17. INFORMANT <u>Ruth Siker</u> | | | | Address <u>4303 Oakridge</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>Cardiac arrest</u> | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO (b) <u>Myocardial Infarction (Post)</u> | | | |
| DUE TO (c) <u>Coronary Occlusion</u> | | | | | | | | | | <u>2 hrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.1</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 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 | | |
| 21. I attended the deceased from <u>9:25 PM</u> to <u>5/5/61</u> and last saw her alive on <u>5/5/61</u> Death occurred at <u>9:25 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Dr. Gordon D. ...</u> | | | | | | 22b. ADDRESS <u>917 Airport Rd</u> | | | 22c. DATE SIGNED <u>5/5/61</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>May 8 1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u> | | | | 23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Math Hermann & Son, Inc., 2161 E. Fair Av</u> | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>5-5-61</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clement McNeary

Licensed Embalmer No. 3732

P. O. Address H. Harris

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.