

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

5383

-61-023370

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED JUN 16 1961

DATE AMENDED

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Missouri		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION @ residence 3935 Kossuth Ave		d. STREET ADDRESS (If outside, give location) 3935 Kossuth Ave.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Mrs. ANNIE Middle Last XENOS			4. DATE OF DEATH Month JUNE Day 18th Year 1961	
---	--	--	--	--

5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/5/1874	9. AGE (last birthday) 86	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-------------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.,	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	-----------------------------------	--	--

13a. FATHER'S NAME John Theidman	13b. MOTHER'S MAIDEN NAME Elizabeth Deters	14. NAME OF HUSBAND OR WIFE Nichlos Xenos
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Agnes Kaeshoefer 3935 Kossuth ave	Address
--	--	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 wks.
DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal pneumonia - Pernicious Anemia for 10 yrs.		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.) 331x
---	---	---

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 1959 , to present and last saw ^{her} _{him} alive on May 31, 1961 Death occurred at 9:45 A. M. m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Paul F. Max M.D. (Degree or title)	22b. ADDRESS 3720 Washington Blvd.	22c. DATE SIGNED 6-8-61
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/12/1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo.,	(State)
--	-------------------------------	---	---	---------

24. FUNERAL DIRECTOR Leidner Und. Co. 2223 St. Louis Ave	25. DATE RECD. BY LOCAL REG. JUN 9 1961	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
--	---	--

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 Mayfield

Licensed Embalmer No. 3077

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.