

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-023445
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1977

AMENDED

FILED JUN 16 1961

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Wellston		c. CITY OR TOWN St. Louis	
Length of stay in 1b 14 months		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rockwood Manor Nursing Home 6470 Plymouth		d. STREET ADDRESS (If outside, give location) 3817 Missouri	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Mathilda Ficken			4. DATE OF DEATH Month May Day 13 Year 1961			
First	Middle	Last	Month	Day	Year	

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 7-7-1883	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Fayette Co., Mo.	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME William Meyer	13b. MOTHER'S MAIDEN NAME Caroline Sachteleben	14. NAME OF HUSBAND OR WIFE Louis
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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. No	17. INFORMANT Mrs. Lillian Rausch	Address 6068 Carlsbad ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic - cardiac - vascular disease		INTERVAL BETWEEN ONSET AND DEATH years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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)	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
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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"/> None	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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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 _____
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21. I attended the deceased from 7-6-60 to 5-13-61 and last saw her alive on 5-12-61
Death occurred at 840 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Allen McNearney MD	(Degree or title)	22b. ADDRESS 4308 Epeter	22c. DATE SIGNED 5-15-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 17, 1961	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery	23d. LOCATION (City, town, or county) (State) 2000 Lemay Ferry Rd. Lemay, Mo.
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24. FUNERAL DIRECTOR C. Hofmeister Mortuaries	ADDRESS 7814 S. Broadway	25. DATE RECD. BY LOCAL REG. 5-16-61	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF THIS RECORD TAKE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

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 John Dennehy

Licensed Embalmer No. 9194

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.