

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **7058**

AMENDED

FILED AUG 8 1961

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		Length of stay in 1b 6 hrs.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis - Little Rock Hospitals, Inc.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1839 South Spring Str., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Albert Middle E. Last Helming			4. DATE OF DEATH Month July Day 28 Year 1961		
5. SEX Male	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 6-10-92	9. AGE (last birthday) 69	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) Superintendent	10b. KIND OF BUSINESS OR INDUSTRY Scrap Iron	11. BIRTHPLACE (City and state or country) Gasconade, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John Helming	13b. MOTHER'S MAIDEN NAME Mary Brown	14. NAME OF HUSBAND OR WIFE Jessie M. Helming	
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.	17. INFORMANT Address Jessie M. Helming, 1839 S. Spring	

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) Cerebral Hemorrhage		12 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Arteriosclerosis	5 yrs
	DUE TO (c) 331X	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Polycythemia Vera Chronic Bronchitis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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"/>	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
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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.) July 1956	20f. CITY, TOWN, OR LOCATION St. Louis, MO	COUNTY	STATE
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21. I attended the deceased from **July 28, 1961** to **July 28, 1961** and last saw him alive on **July 28, 1961**
Death occurred at **7:35 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. W. Correy MD	(Degree or title)	22b. ADDRESS 5720 Washington St. Louis 8, MO	22c. DATE SIGNED 7/29/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-31-1961	23c. NAME OF CEMETERY OR CREMATORY Frieden's Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.
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24. FUNERAL DIRECTOR Kriegshauser Mortuary - St. Louis, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 30 1961	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

11/20/51

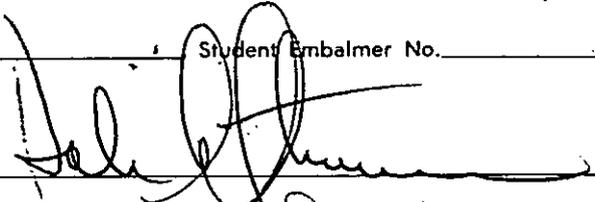
St. Louis 8
St. Louis 8
St. Louis 8 - Little Rock
St. Louis 8 - Little Rock

Albert
X
10-10-51
10-10-51

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 _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 
Student Embalmer No. _____

Licensed Embalmer No. 4533
P. O. Address St. Louis

10-10-51
10-10-51
10-10-51

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.