

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027609

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2120

AMENDED

FILED AUG 14 1961

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b <u>2 weeks</u> | c. CITY OR TOWN <u>St. Louis</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>Gravois Rest Haven</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>6408a Morganford</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|---|--|---|---|---|
| 3. NAME OF DECEASED (Type or print) First <u>EMILIE</u> Middle <u>DEHNE</u> Last | | | 4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1961</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</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>11/27/80</u> | 9. AGE (last birthday) <u>80</u> | 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) <u>At Home- Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>Charles Frank</u> | | 13b. MOTHER'S MAIDEN NAME <u>Marie Scheele</u> | | 14. NAME OF HUSBAND OR WIFE <u>Ferdinand Max Dehne</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> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. Ella Ragotzkie, 3710a Winnebago (16)</u> | | |

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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) <u>Arterio-sclerotic - Heart - Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>years</u> |
| DUE TO (b) <u>Arterio-sclerotic - Cerebrovascular Disease - Chronic Brain Syndrome</u> | | |
| DUE TO (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>422.1</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 |

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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"/> <u>None</u> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | 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 7-14-61 to 7-27-61 and last saw her ^{her} _{him} alive on 7-19-61
Death occurred at 1225 9th St on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>Allen D. Kearney M.D.</u> (Degree or title) | | 22b. ADDRESS <u>4308 E. 24th</u> | | 22c. DATE SIGNED <u>7-29-61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>July 31, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Beiderwieden F.H.Inc., 1936 St. Louis (6)</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-29-61</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Muffley M.D.</u> | | |

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

11-12 Seal

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 Homer W. Fritz

Licensed Embalmer No. 3882

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.