

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027821

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2115

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FILED AUG 3 1961

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Breckenridge Hills Length of stay in 1b 6 weeks
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 3206 Calvert Ave. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Breckenridge Hills Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 3206 Calvert Ave. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Lydia Middle Louise Last Persson
4. DATE OF DEATH Month July Day 28 Year 1961

5. SEX F 6. COLOR OR RACE W 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 2-8-1882 9. AGE (last birthday) 79 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) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (City and state or country) New Minden, Ill. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Henry Heidenreich 13b. MOTHER'S MAIDEN NAME Louise Hoelscher 14. NAME OF HUSBAND OR WIFE Gustav A. (dcd).

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. None 17. INFORMANT Breckenridge Hills Louise Herrmann-3206 Calvert

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Cardiovascular Renal Disease
DUE TO (c) Arterio-sclerotic Heart Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Vascula accident, cholelithiasis, myxedema
PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 march 1960 to 7-28-61 and last saw her/him alive on 7-27-61
Death occurred at 10 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Maxwell Richardson DO 22b. ADDRESS 9553 Lochland Rd 22c. DATE SIGNED 7-28-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal- 23b. DATE 7-31-61 23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem. 23d. LOCATION (City, town, or county) (State) Nashville, Ill.

24. FUNERAL DIRECTOR Baumann Bros. Inc. ADDRESS 2504 Woodson Rd 25. DATE RECD. BY LOCAL REG. 7-29-61 26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

Overland 14 (Licensed Embalmer's Statement on Reverse Side)

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 David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Portland

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.