

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registered District No. **318** Primary Registration District No. **1003** Registrar's No. **8898**

-61-034388
 STATE FILE NUMBER

| | | | | | |
|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 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 St. Louis | | Length of stay in 1b | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 5353 Lindenwood Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First FRED Middle HADERFELD Last HADERFELD | | | 4. DATE OF DEATH Month Sep. Day 25 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 10-6-1894 | 9. AGE (last birthday) 66 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard | | 10b. KIND OF BUSINESS OR INDUSTRY Anheuser-Busch Inc. | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Herman Haderfeld | | 13b. MOTHER'S MAIDEN NAME Wilhelmina Hartman | |
| 14. NAME OF HUSBAND OR WIFE Catherine E. Haderfeld | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes world war I | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Catherine E. Haderfeld | | Address 5353 Linden- | | WOOD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disease of Coronary Arteries DUE TO (b) Arteriosclerosis Conditions, if any, which give rise to (a) stating the underlying cause (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (d) Cerebral Arteriosclerosis | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 mo 1 yr + |
| 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 | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) | |
| 20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Jan 1952 to 9-25-1961 and last saw him alive on 5/25/61 Death occurred at 10:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Robert P. Smith M.D. | | | 22b. ADDRESS 5203 Chiffeyn N | | 22c. DATE SIGNED 9/26/61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Sep. 28, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. |
| 24. FUNERAL DIRECTOR Kriegshauser | | ADDRESS 4228 S. Kingshighway | | 25. DATE RECD. BY LOCAL REG. SEP 26 1961 | 26. REGISTRAR'S SIGNATURE Robert P. Smith M.D. |

DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 William B. White

Licensed Embalmer No. 4291

P. O. Address _____

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.