

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9120 STATE FILE NUMBER -61-034466

FILED OCT 13 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>Clayton</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>520 S. Hanley Rd.</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle Last <u>HORST</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</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>11-13-1894</u>
9. AGE (last birthday) <u>66</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>Clerk-Hoffner Bros.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Edward Diehl</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Yoerg</u>	
14. NAME OF HUSBAND OR WIFE <u>Late John Horst</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>John Horst R.R.#1 Cedar Hill, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
DUE TO (b) <u>Arteriosclerosis</u>			<u>67 years</u>
DUE TO (c) <u>Hypertension 331x</u>			<u>7-8 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</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
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 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
21. I attended the deceased from <u>Sept 19 1961</u> to <u>Oct 2, 1961</u> and last saw her/him alive on <u>Oct 1, 1961</u> Death occurred at <u>1:10 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Keith S. Wilson, M.D.</u>		22b. ADDRESS <u>52 Maryland Plaza</u>	22c. DATE SIGNED <u>10-3-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Oct. 4, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S. Kingshighway Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 3 1961</u>	26. REGISTRAR'S SIGNATURE <u>Keith S. Wilson, M.D.</u>

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
ITEM NO. SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**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.