

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-034813

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8889

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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4249 DELOR ST</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4249 DELOR ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES A PROEHL</u>			4. DATE OF DEATH Month Day Year <u>SEPT 23 1961</u>		
---	--	--	---	--	--

5. SEX <u>MALE</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>SEPT. 18 1892</u>	9. AGE (last birthday) <u>69</u>	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) <u>RETIRED WATCHMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>
--	-----------------------------------	---	---

13a. FATHER'S NAME <u>GUSTAV PROEHL</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>ANNA PROEHL (DEC'D)</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> </u>	17. INFORMANT <u>WALTER PROEHL 4600th VARRELMANN</u> Address
---	--	---

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) <u>Cerebrovascular Accident</u>		<u>Sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized Arteriosclerosis</u>	
	DUE TO (c) <u>331x</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (g) <u>Arteriosclerotic Heart Disease</u>	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 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.)
---	---	--

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>Jan 26, 1961</u> to <u>Sept 23, 61</u> and last saw ^{HER} him alive on <u>9/23/61</u> Death occurred at <u>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>Garwood Hendrix M.D.</u>	22b. ADDRESS <u>4268 Delor</u>	22c. DATE SIGNED <u>9/25/61</u>
---	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>SEPT 26 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS CO. MO.</u>
---	----------------------------------	--	---

24. FUNERAL DIRECTOR <u>Thomas Kutek 2906 Gravois</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>SEP 26 1961</u>	26. REGISTRAR'S SIGNATURE <u>Coat Smith M.D.</u>
---	--	---

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 *Barry Thompson*

Licensed Embalmer No. 4861

P. O. Address Blair 5, Mo

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.