

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035218
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2691

FILED SEP 27 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		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>Webster Groves</u>		c. CITY OR TOWN <u>Webster Groves</u>	
Length of stay in 1b <u>11 yrs.</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>507 Elizabeth Drive</u>		d. STREET ADDRESS (If outside, give location) <u>507 Elizabeth Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>Ann</u> Last <u>Charleville</u>		4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</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>8-7-'84</u>
9. AGE (last birthday) <u>77</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</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>William Schaefer</u>		13b. MOTHER'S MAIDEN NAME <u>Kate Richards</u>	
14. NAME OF HUSBAND OR WIFE <u>Benj. J. Charleville</u>		Address _____	
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 <u>Wesley R. Charleville</u>		Address <u>507 Elizabeth Dr.</u>	
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>Pneumonia (Hypostatic)</u>			<u>4 days</u>
DUE TO (b) <u>Cerebral Accident</u>			<u>First - 4 1/2 yrs</u>
DUE TO (c) <u>arterial Sclerotic Heart Disease</u>			<u>Second - 10 days</u>
DUE TO (c) <u>General Arterial Sclerosis</u>			<u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hemiplegia (Mild) Right side - 4 1/2 yrs</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
<u>Left side - 10 days</u>			
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>June 1957</u> to <u>Sept. 22, 1961</u> and last saw her <u>alive on Sept. 22, 1961.</u>			
Death occurred at <u>8:40 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Mrs. W. Norton, M.D.</u>		22b. ADDRESS <u>634 No. Grand - St. Louis, Mo</u>	
22c. DATE SIGNED <u>9-23-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	23b. DATE <u>9-23-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Mittelberg Webster Groves, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9/23/61</u>	
		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

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 *Lawrence Habbe*

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.