

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035243
STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2755

FILED OCT 9 1961

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy Length of stay in lb YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mother of Good Counsel Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY ST Louis
c. CITY OR TOWN Normandy Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 6825 Naturel Bridge Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First ELLEN Middle DOSENBACH Last DOSENBACH
4. DATE OF DEATH Month Sept. Day 30th Year 1961

5. SEX Female **6. COLOR OR RACE** White **7. Married** Never Married Widowed Divorced
8. DATE OF BIRTH 9/2/1881 **9. AGE** (last birthday) 80 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** Home **11. BIRTHPLACE** (City and state or country) Missouri **12. CITIZEN OF WHAT COUNTRY** U.S.A.

13a. FATHER'S NAME Julius Reichardt **13b. MOTHER'S MAIDEN NAME** Unknown **14. NAME OF HUSBAND OR WIFE** Deceased

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** Mr. G. Dosenbach 4731 Beacon Ave. Address 4731 Beacon Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO (b) Arteriosclerosis
DUE TO (c)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none
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.) none

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year none

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.) none **20f. CITY, TOWN, OR LOCATION** **COUNTY** **STATE**

21. I attended the deceased from 4-4-32 to Sept 30 61 and last saw her alive on Sept 1 61
Death occurred at 8:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M E Staehle M D (Degree or title) **22b. ADDRESS** 7124 Naturel Bridge **22c. DATE SIGNED** 9.30.61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal **23b. DATE** 10/2/61 **23c. NAME OF CEMETERY OR CREMATORY** Mt. Hope Cemetery **23d. LOCATION** (City, town, or county) (State) Perryville, Missouri.

24. FUNERAL DIRECTOR JOHN STYGAR & SON 5541 Riverview Blvd. ADDRESS **25. DATE RECD. BY LOCAL REG.** 9-30-61 **26. REGISTRAR'S SIGNATURE** John B. Murphy M.D.

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 *W. Rister*

Licensed Embalmer No. 3980

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.