

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9907

-61-038928
STATE FILE NUMBER

FILED NOV 8 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis City</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis City</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis City</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis, Mo.</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>Lutheran Hosp's</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6910 Lytle Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>A.</u> Last <u>Maier</u>			4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>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>9-8-1873</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer-Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Tella, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Frederick Maier</u>		13b. MOTHER'S MAIDEN NAME <u>Addie Seidel</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah K. Turner, 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>None</u>	17. INFORMANT <u>Albert K. Maier (By Pre Arrangement)</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>MYOCARDIAL FAILURE</u>					<u>9 days</u>
DUE TO (b) <u>PERICARDITIS</u>					<u>unknown</u>
DUE TO (c) <u>PNEUMONIA</u>					<u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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>October 14, 1961</u> to <u>Oct 24, 1961</u> and last saw her/him alive on <u>Oct 23, 1961</u> Death occurred at <u>10:20 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Joseph A. Fudge M.D.</u> (Degree or title)			22b. ADDRESS <u>3228 Ivanhoe</u>		22c. DATE SIGNED <u>10/26/61</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>October 26, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
24. FUNERAL DIRECTOR <u>W.P. Thomas Cuba, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 26 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u>	

37
8
1-19-59
7 P.M.
D. J. ...
D. J. ...

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 Paul J. Franklin
Licensed Embalmer No. 3472

P. O. Address Cuba, 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.