

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042562

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10845

STATE FILE NUMBER

FILED NOV 28 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>		Length of stay in 1b <u>11 days</u>	c. CITY OR TOWN <u>Gardenville</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>St John Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4985 Seibert</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>C</u> Last <u>Jennewein</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</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>4/22/93</u>	9. AGE (last birthday) <u>68</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</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>	11. BIRTHPLACE (City and state or country) <u>St Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Christian Jennewein</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Welek</u>		14. NAME OF HUSBAND OR WIFE <u>Anna - - -deceased</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.		17. INFORMANT <u>Laura Kuhnel</u> Address <u>4710 Seibert</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF ESOPHAGUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>150x</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	
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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.)	
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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 <u>St Louis Co.</u>	COUNTY <u>Mo.</u>	STATE
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21. I attended the deceased from 7-1-61 to 11-20-61 and last saw ^{her}him alive on 11-20-61
Death occurred at 2 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>William Seelig MD</u> (Degree or title)	22b. ADDRESS <u>3720 Washington</u>	22c. DATE SIGNED <u>11-20-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11/22/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>John L Ziegenhein & Sons 7027 Gravois</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>NOV 21 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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DATE AWARDED BY OFFICIAL OF HEALTH DEPARTMENT SHOULD READ BY AFFIDAVIT OF ITEM NO.

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

Donald B. King

Licensed Embalmer No. 4863

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.