

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046728

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **12347**

AMENDED

FILED JAN 11 1967

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 Weeks	
c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If outside, give location) 5568 Pershing	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Dorothy Middle Emily Last PANHORST			4. DATE OF DEATH Month December Day 29 Year 1961			
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5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-2-1901	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper	10b. KIND OF BUSINESS OR INDUSTRY Hussmann Refridgerator	11. BIRTHPLACE (City and state or country) Stanton, Ill.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Henry Otto Panhorst	13b. MOTHER'S MAIDEN NAME Josephine Klinefelter	14. NAME OF HUSBAND OR WIFE -----
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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. -----	17. INFORMANT Indianapolis, Ind. Mrs. Rosa Panhorst, 538 N. La Salle,
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia		INTERVAL BETWEEN ONSET AND DEATH 14 days
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) Renal Shut down	
	DUE TO (c) Filly of Bladder Tumor (grade #) 181.0	

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 checked="" 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	COUNTY	STATE
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21. I attended the deceased from **12-14-61** to **12-29-61** and last saw her/him alive on **12/28/61**
Death occurred at **3:40 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. M. Gronberg M.D.	(Degree or title)	22b. ADDRESS 7652 Maryland Dr. Oak, Mo	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-30-61	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) Stanton, Ill.
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24. FUNERAL DIRECTOR Alexander & Sons, 6175 Delmar Blvd.	ADDRESS	25. DATE RECD. BY LOCAL REG. DEC 30 1961	26. REGISTRAR'S SIGNATURE Loed Smith M.D.
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

By Affidavit of **Loed Smith - Malignant**

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 Joe E. Macaulloch

Licensed Embalmer No. 2460

P. O. Address 6135 Palm

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.