

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047302

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3680

STATE FILE NUMBER

AMENDED

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>CLAYTON</u>		Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>VELDA VILLAGE</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>ST LOUIS CO HOOP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7474 ST CHARLES RD</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>MAYER</u> Last <u>MAYER</u>			4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>61</u>
5. SEX <u>FEMALE</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>9-2-1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE (last birthday) <u>64</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10c. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		11. BIRTHPLACE (City and state or country) <u>HEBARDON ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>GEORGE SUNNENBERG</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>JOSEPH MAYER (DEAD)</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>		17. INFORMANT Address <u>OFALLON MO</u> <u>JOSEPH S. MAYER 606 W. RIDGE</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>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Heart Disease Chronic</u> DUE TO (c) <u>Atherosclerosis, General</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>3 yrs</u> <u>5 yrs.</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 checked="" 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 - Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Charles F. Kohn, MD</u> (Doctor or title)		22b. ADDRESS <u>601 S. Brentwood</u>	22c. DATE SIGNED <u>12/26/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12-26-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT ZION</u>	23d. LOCATION (City, town, or county) (State) <u>OFALLON MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Carl Hilleman Orland MO</u>		25. DATE RECD. BY LOCAL REG. <u>12-26-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>

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 Earl S. Helman

Licensed Embalmer No. 101

P. O. Address Oreland 14 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.