

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-003935

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

992

FILED FEB 2 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b 6 1/2 Yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Good Samaritan Home		d. STREET ADDRESS (If outside, give location) 5200 S. Broadway	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Anna Martha Horstman	4. DATE OF DEATH Month Day Year 1 20 1962
--	---

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-22-75	9. AGE (last birthday) 86	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
------------------	---------------------------	---	-----------------------------	------------------------------	---	----------------

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) Allentown, Pa.	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	--	---------------------------------------

13a. FATHER'S NAME John Stoehr	13b. MOTHER'S MAIDEN NAME Louise Schleicher	14. NAME OF HUSBAND OR WIFE Charles E. Horstman
-----------------------------------	--	--

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 H.E. Koenig, 5200 S. Broadway
--	---------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac failure</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 hr</i>
--	---

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) *Arteriosclerotic heart disease*

DUE TO (c) *Sen. arteriosclerosis*

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Senility 4200

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No 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 s.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 *1/2/62* to *1/20/62* and last saw her alive on *1/19/62*
Death occurred at *12:45 P* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>W.T. Heenan MD</i> (Degree or title)	22b. ADDRESS <i>5203 Chippenwa</i>	22c. DATE SIGNED <i>1/24/62</i>
---	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 1-23-62	23c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery	23d. LOCATION (City, town, or county) St. Louis County Mo.
--	----------------------	---	---

24. FUNERAL DIRECTOR Drehmann-Harral, 1905 Union Blvd.	25. DATE RECD. BY LOCAL REG. JAN 23 1962	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
---	---	--

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Wm. F. Neun
5203 Chippewa
Fl 2-6670
Hrs.

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 Albert R. Thompson

Licensed Embalmer No. 4937

P. O. Address St. Louis

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.