

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-004558

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

1403

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1403

FILED FEB 7 1962

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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>                 |  | c. CITY OR TOWN <u>St. Louis</u>   |  |
| Length of stay in 1b  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>6646 O'Dell St.</u> |  | d. STREET ADDRESS (If outside, give location)<br><u>6646 O'Dell St.</u>  |  |
| Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                             |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |

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| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>CAROLINE(CARRIE) C. SOFFNER</u> |  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>Jan. 31 1962</u> |  |  |
|--|--|--|---|--|--|

|                         |                                  |   |                                      |                                     |                                |                              |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--------------------------------|------------------------------|
| 5. SEX<br><u>Female</u> | 6. COLOR OR RACE<br><u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-5-1892</u> | 9. AGE (last birthday)<br><u>69</u> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--------------------------------|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housework</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u> | 11. BIRTHPLACE (City and state or country)<br><u>St. Louis, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u> |
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| 13a. FATHER'S NAME<br><u>William Lehmann</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Caroline Gotz</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Herman A. Soffner</u> |
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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)<br><u>No</u> | 17. INFORMANT Address<br><u>Herman A. Soffner 6646 O'Dell St.</u> |
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| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Heart Block Complete</u>   |  | <u>2 yrs</u>                     |
| DUE TO (b) <u>Myocarditis</u>   |  | <u>2 yrs</u>                     |
| DUE TO (c) <u>My pericarditis</u>   |  | <u>8 yrs.</u>                    |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>443x</u> | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED?<br>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.) |
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| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>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<br>COUNTY STATE |
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| 21. I attended the deceased from <u>11-6-58</u> to <u>1-30-62</u> and last saw her alive on <u>1-30-62</u><br>Death occurred at <u>1:45 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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|   |                                      |                                    |
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| 22a. SIGNATURE (Degree title)<br><u>Arnold Dohms M.D.</u> | 22b. ADDRESS<br><u>1452 So Grand</u> | 22c. DATE SIGNED<br><u>1-31-62</u> |
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|   |                                  |  |   |
|---|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u> | 23b. DATE<br><u>Feb. 3, 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Resurrection Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis Co. Mo.</u> |
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| 24. FUNERAL DIRECTOR ADDRESS<br><u>Kriegshauser 4228 S. Kingshighway Blvd.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>FEB 1 1962</u> | 26. REGISTRAR'S SIGNATURE<br><u>Loan Smith. M.D.</u> |
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

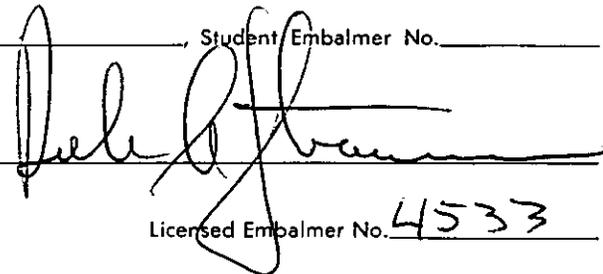
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

  
\_\_\_\_\_

Licensed Embalmer No. 4533

P. O. Address \_\_\_\_\_

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.