

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-004856

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 73

FILED JAN 19 1962

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Valley Park</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>St. Louis,</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Valley Park</u>		Length of stay in lb <u>4 days</u>		c. CITY OR TOWN <u>Richmond Heights</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>Mott Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>9350 Parkside Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First <u>Henry</u>		Middle <u>Elias</u>		Last <u>Ehrensperger</u>		Month <u>1</u>		
Day <u>8</u>		Year <u>1962</u>						
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>11-2-'76</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lily Vannish Co.</u>		11. BIRTHPLACE (City and state or country) <u>Tell City Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Albert Ehrensperger</u>			13b. MOTHER'S MAIDEN-NAME <u>Hanna Kueser</u>			14. NAME OF HUSBAND OR WIFE <u>Stella Pugh Ehrensperger</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. <u>[REDACTED]</u>		17. INFORMANT <u>Edith Ehrensperger 9350 Parkside Dr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line)							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:							<u>1 Mo.</u>	
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) _____								
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of left hip</u>					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			
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.) <u>Fell at home about two months ago</u>				
20c. TIME OF INJURY Hour <u>?</u> a.m. p.m.	Month, Day, Year <u>- -61</u>							
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 <u>Jan. 4, 1962</u> to <u>Jan. 5, 1962</u> and last saw ^{her} him alive on <u>Jan. 4, 1962</u> Death occurred at <u>8:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Colut A. Sanders, M.D.</u>				22b. ADDRESS <u>1507 Cass Av</u>		22c. DATE SIGNED <u>1-8-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>1-10-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Mittelberg</u>			ADDRESS <u>Webster Groves, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-8-62</u>		26. REGISTRAR'S SIGNATURE <u>J. B. Murphy, M.D.</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 *Pat Embalmer* _____

Licensed Embalmer No. _____

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.