

# MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009241

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

FILED FEB 23 1962
Primary Registration District No. 590
Registrar's No. 376
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59	DATE AMENDED									
14010		AMENDMENTS ON THIS RECORD ARE AS FOLLOWS								
24010			INSTEAD OF							
3				DOCUMENT						
4 1					MEDICAL CERTIFICATION					
5 2						BY AFFIDAVIT OF				
6										
7 2										
8 2										
94200										
10										
11										
12 90-0										
13										

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Berkeley</u>			Length of stay in lb <u>7 months</u>	c. CITY OR TOWN <u>Berkeley</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>4313 Rolling Dr.</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4313 Rolling Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>ELSA</u>			First	Middle	Last	4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1962</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>9/22/1886</u>	9. AGE (last birthday) <u>75 years</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Paul Grausam</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Scheibert</u>			14. NAME OF HUSBAND OR WIFE <u>Andrew Kettenbach</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.		17. INFORMANT Address <u>Helen Hoven - 4313 Rolling Dr.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CORONARY INSUFFICIENCY</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
DUE TO (c) _____							
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 _____ a.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 <u>12/24/60</u> to <u>1/27/62</u> and last saw her/him alive on <u>1/26/62</u> Death occurred at <u>10:15 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Carl W. Lumaner, M.D.</u>				22b. ADDRESS <u>6000 WEST FLORISSANT</u>		22c. DATE SIGNED <u>1/29/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Jan 31, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) <u>St. Louis County</u>		(State) <u>Missouri</u>
24. FUNERAL DIRECTOR <u>BUCHHOLZ MORTUARY-5967 W. Florissant Ave</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-29-62</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

**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

*Robert C. Lindner*

Licensed Embalmer No. 4275

P. O. Address St. Louis, 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.