

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-016889

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3851

FILED APR 25 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b <u>16 DAYS</u>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. ANTHONY'S HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>320 EAST RIPA (25)</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>SISTER M. DATIVA HOERSCHEN</u>			4. DATE OF DEATH Month Day Year <u>APRIL 10 1962</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/82</u>
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>LOOSE CREEK, MO.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>JAMES HOERSCHEN</u>	
13b. MOTHER'S MAIDEN NAME <u>ELIZABETH TROESSER</u>		14. NAME OF HUSBAND OR WIFE	
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 <u>SISTER KATHLEEN, 320 EAST RIPA</u> Address
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>Carcinoma of ovary</u> <u>Generalized Arteriosclerosis.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>1750.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
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>1961</u> to <u>Death</u> and last saw her/him alive on <u>11-april 62</u> . Death occurred at <u>8:35 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John H. Kellett</u> (Typed or title)		22b. ADDRESS <u>2623 Telegraph</u>	22c. DATE SIGNED
23a. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>APR 13 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NOTRE DAME MOTHERHOUSE</u>	23d. LOCATION (City, town, or county) (State) <u>LEMAY MO.</u>
24. FUNERAL DIRECTOR <u>Thomas Katis 2906 Gravois</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>APR 12 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 Eleanore Province

Licensed Embalmer No. 3403

P. O. Address 2906 Javan

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.

Dr. Kelleth
2623 TELEGRAPH RD
11-4 PM
TW 2-3500