

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-017355

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4028**

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 25 1962

VS 300
Rev. 4/59

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DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Missouri | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 32 Yrs. | c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1740 Dolman | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1740 Dolman Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR M. VEHLEWALD | | | 4. DATE OF DEATH Month Day Year April 15, 1962 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7/25/97 |
| 9. AGE (last birthday) 64 | | 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) Pump Operator | | 10b. KIND OF BUSINESS OR INDUSTRY American Marietta Company | 11. BIRTHPLACE (City and state or country) Missouri |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME John Vehlewald | |
| 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Nettie | |
| 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. Yes (Unk) | 17. INFORMANT Nettie Vehlewald, 1740 Dolman, St. Louis, Mo. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular heart disease hypertension hemiplegia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Hemiplegia | | | 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) 721.4 | | | 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.) | |
| 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 3-31-62 to 4-10-62 and last saw her alive on 4-10-62 Death occurred at 6 pm 4/15/62 m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE A. Bouhasin (Degree or title) A. Bouhasin M.D. | | 22b. ADDRESS 2021 Park | 22c. DATE SIGNED 4/16/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 4/18/62 | 23c. NAME OF CEMETERY OR CREMATORY St. Trinity | 23d. LOCATION (City, town, or county) St. Louis Co., Mo. |
| 24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette, | | 25. DATE RECD. BY LOCAL REG. APR 18 1962 | 26. REGISTRAR'S SIGNATURE Roan Smith, M.D. |

DR. BOUHASIN
2021 PARK
MA 1-7714

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

Janna R. Chapman

Licensed Embalmer No. 4552

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.