

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025148

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6621** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 12 1962

VS 300
Rev. 4/59

DATE AMENDED

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2 **203**

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59

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY			
		St Louis				MO		St Louis			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits		d. STREET ADDRESS (If outside, give location)					
DePaul Hospital				Yes <input type="checkbox"/> No <input type="checkbox"/>		2736 So 59th St.					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH			
		Minnie		A		Scheer		Month Day Year July 3 1962			
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)			
Female		White				12/23/1877		84			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
at home						St. Louis, Mo.		USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE			
Herman Hakemeier				Wilhelmina Rockledge				Henry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
NO				none				Dorothy Cummins 2736A S 59th St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Cerebral Vasculardisease</i>											
DUE TO (b) <i>334XF</i>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease or condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days.			
<i>fracture femur</i>								<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 checked="" 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.)							
				<i>Fell on Tower</i>							
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 checked="" 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			
		<i>home</i>		<i>St Louis</i>				<i>Mo</i>			
21. I attended the deceased from <i>7-5-62</i> to <i>7-2-62</i> and last saw her alive on <i>7-2-62</i> Death occurred at <i>10</i> a m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title)						22b. ADDRESS		22c. DATE SIGNED			
<i>H. H. Feller MD</i>						<i>2739 N Grand</i>		<i>7-3-62</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)			
removal		7/5/1962		Laurel Hill Gardens		St. Louis County, Mo.					
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
John L Ziegenhein & Sons 7027 Gravois				JUL 5 1962		<i>Joan Smith, M.D.</i>					

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 G. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Brauns

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.