

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025443

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1725

DO NOT WRITE ON THIS STUB

AMENDED

DECEASED JUN 20 1962

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo COUNTY St Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		c. CITY OR TOWN Maryladd Hgts	
Length of stay in 1b 2 da		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Louis Co Hosp		d. STREET ADDRESS (If outside, give location) 11045 Ayrshire	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Joseph W DeHekker			4. DATE OF DEATH Month Day Year June 10 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 1/25/1898	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Own Shop		11. BIRTHPLACE (City and state or country) St Louis Mo	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME John DeHekker		13b. MOTHER'S MAIDEN NAME Mary Donnelly	
14. NAME OF HUSBAND OR WIFE Celestine DeHekker		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. [REDACTED]	
17. INFORMANT Celestine DeHekker		Address 11045 Ayrshire			

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH
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)		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	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 **6-8-62** to **6-10-62** and last saw him alive on **6-10-62**. Death occurred at **5:40 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Albert L. Howe MD. (Degree or title)	22b. ADDRESS 601 S. S. Brentwood Clayton, Mo	22c. DATE SIGNED 6-10-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/12/62	23c. NAME OF CEMETERY OR CREMATORY YALHALLA	23d. LOCATION (City, town, or county) (State) St Louis Co Mo
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24. FUNERAL DIRECTOR Ortmann F Home	ADDRESS 9222 Lackland Overland Mo	25. DATE RECD. BY LOCAL REG. 6-10-62	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 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 McC Ostrom

Licensed Embalmer No. 3478

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.