

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-029452

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2138

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 31 1962

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Affton</u>		Length of stay in 1b <u>10 mo.</u>	c. CITY OR TOWN <u>Millstadt</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>Affton Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>320 West White</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First <u>Christine</u> Middle <u>Guckes</u> Last <u>Guckes</u>			4. DATE OF DEATH Month <u>7</u> Day <u>21</u> Year <u>62</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>1/14/1874</u>
9. AGE (last birthday) <u>88</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Millstadt, Ill.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Thomas Mueller</u>	
13b. MOTHER'S MAIDEN NAME <u>Helen Brugg</u>		14. NAME OF HUSBAND OR WIFE <u>- -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Fred H Guckes 199 Mill Millstadt Ill</u> Address <u> </u>
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>Arterio-sclerotic Heart Disease</u> DUE TO (b) <u>Arterio-sclerotic Cardiac Vasculature Disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Ceculitis Left Leg - Fungus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 yrs?</u> <u>30 yrs?</u>
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"/> <u>NONE</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>		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 <u> </u> COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>Oct 1961</u> to <u>7-21-62</u> and last saw her alive on <u>7-18-62</u> Death occurred at <u>130 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Allen M. Kearney M.D.</u> (Degree or title)		22b. ADDRESS <u>4308 Empster</u>	22c. DATE SIGNED <u>7-22-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>7-23-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Evergreen</u>	23d. LOCATION (City, town, or county) (State) <u>Millstadt Ill</u>
24. FUNERAL DIRECTOR <u>Strauss Fun'l Home Millstadt, Ill</u> ADDRESS <u> </u>		25. DATE RECD. BY LOCAL REG. <u>7-22-62</u>	26. REGISTRAR'S SIGNATURE <u>John Murphy M.D.</u>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59
4000
28120
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94221
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1286-0
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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 Kenn Proff

Licensed Embalmer No. 4356

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.