

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-032949

Registration District No. **318** Primary Registration District **1003** Registrar's No. **8326** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

FILED AUG 31 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY St. Louis</p> <p>b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in lb Lifetime</p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE MO. b. COUNTY</p> <p>c. CITY OR TOWN St. Louis Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. STREET ADDRESS (if outside, give location) 5361 Claxton Ave Residence on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
<p>3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year</p> <p style="text-align: center;">MATHILDA SUEDMEYER August 25 1962</p>	
<p>5. SEX Female 6. COLOR OR RACE White 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> 8. DATE OF BIRTH 8/19/1888 9. AGE (last birthday) 74 IF UNDER 1 YEAR IF UNDER 24 HR.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and state or country) St. Louis MO. 12. CITIZEN OF WHAT COUNTRY USA</p>	
<p>13a. FATHER'S NAME Unknown Ziern 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE Emil Suedmeyer (deceased)</p>	
<p>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. None 17. INFORMANT Russell F. Suedmeyer Address 5316 Claxton Ave</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p style="text-align: center;">PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) Hypertensive Myocarditis INTERVAL BETWEEN ONSET AND DEATH -?</p> <p style="text-align: center;">DUE TO (b) 443x</p> <p style="text-align: center;">DUE TO (c)</p> <p style="text-align: center;">PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus</p> <p style="text-align: center;">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</p>	
<p>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.)</p>	
<p>20c. TIME OF INJURY Hour Month, Day, Year</p> <p style="text-align: center;">a.m. p.m.</p>	
<p>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</p>	
<p>21. I attended the deceased from Oct 22-1951 to Aug 25-1962 and last saw her ^{him} alive on Aug 22-1962</p> <p style="text-align: center;">Death occurred at 6:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) John G. McJorney M.D. 22b. ADDRESS 5014 Thekla Av 22c. DATE SIGNED 8/27/62</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 8/28/1962 23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery 23d. LOCATION (City, town, or county) St. Louis MO.</p>	
<p>24. FUNERAL DIRECTOR ADDRESS SUEDMEYER & SON'S 3934 N. 20th Street 25. DATE RECD. BY LOCAL REG. AUG 27 1962 26. REGISTRAR'S SIGNATURE Roald Smith M.D.</p>	

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DATE AMENDED
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 John J. Harris

Licensed Embalmer No. 4608

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.