

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037201

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2599

DO NOT WRITE ON THIS SUB

AMENDED

FILED SEP 20 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>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>OLIVETTE</u>		Length of stay in 1b <u>YRS.</u>	c. CITY OR TOWN <u>OLIVETTE</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>OLD BONHOMME RESTORIAN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9564 OLD BONHOMME RD</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET SEIDLITZ</u>			4. DATE OF DEATH Month Day Year <u>SEPT 5 1962</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>9/16/1865</u>	9. AGE (last birthday) <u>96</u>	IF UNDER 1 YEAR Months Days Hours Min.
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>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>GEORGE FICHEL</u>		13b. MOTHER'S MAIDEN NAME <u>WILHELMINA PRACHT</u>		14. NAME OF HUSBAND OR WIFE <u>CHARLES SEIDLITZ, LATE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MABEL SEIDLITZ 548 MAPLEVIEW</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>Cerebro-vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u>		<u>yes</u>
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 checked="" 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 <u>ST. LOUIS</u>	COUNTY <u>ST. LOUIS</u>	STATE <u>MO</u>
21. I attended the deceased from <u>9/1/58</u> to <u>9/5/62</u> and last saw her/him alive on <u>9/1/62</u> Death occurred at <u>1:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Sam Dean MD</u> (Degree or title)	22b. ADDRESS <u>35 W Central - Shaver Pl</u>	22c. DATE SIGNED <u>9/6/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9/17/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>LUPTON CHAPEL, INC 7233 DELMAR</u>	25. DATE RECD. BY LOCAL REG. <u>9-7-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59	
1 4033	
2 4033	
3	
4 1	
5 2	
6	
7 0	
8 2	
9 331X	
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11	
12 86-0	
13	

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 Clarence H. Murray

Licensed Embalmer No. 4604

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.