

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040177

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10196**

FILED NOV 13 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
DATE AMENDED
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		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
		St. Louis		Byr. 31 days		Mo.				St. Louis		Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)						Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
Chronic Hospital						3935 Oregon													
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH		Month		Day		Year	
			Ida			Eimer						10		25		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)		IF UNDER 1 YEAR		IF UNDER 24 HR							
Female		White				7/29/1872		90		Months		Days		Hours		Min.			
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							
Housewife								Mo.				U.S.							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE											
George (Unknown)				Josephine (Unknown)				August											
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				Robert L. Schneider, Pub. Adm.				St. Louis, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a)												Arteriosclerotic Heart Disease							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												4200							
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 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				COUNTY		STATE					
21. I attended the deceased from <u>11/25/58</u> to <u>10/25/62</u> and last saw ^{her} / _{him} alive on <u>10/25/62</u> Death occurred at <u>8:30 AM</u> 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>Dr. R. Christ - MD</i>						5800 Arsenal St.						10-26-62							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				(State)							
Burial		11-2-62		Calvary Cemetery				St. Louis, Mo.											
24. FUNERAL DIRECTOR						ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE									
Albert H. Hoppe, Inc., 4700 Washington Blvd,								NOV 1 1962		<i>Roan Smith MD</i>									

USE BLACK INK OR TYPEWRITER RIBBON

76

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 W W Wilkinson

Licensed Embalmer No. 3575

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.