

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-041031

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2919

FILED NOV 13 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

14000

2 2159

3

4 1

5 0

6

7 0

8 2

9 5703

10

11

12 41-0

13

41

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Mo.</u>		Length of stay in lb <u>251 days</u>	c. CITY OR TOWN <u>ST. Louis Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4438 Beck</u>
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>K. Hagelberg</u> Last <u></u>		4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>62</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/5/76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>ST. Louis</u>
13a. FATHER'S NAME <u>William Hagelberg</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Bomestein</u>	14. NAME OF HUSBAND OR WIFE <u>Single</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 <u>patient's history Koch Record</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>Gangrene of descending colon & sigmoid</u> DUE TO (b) <u>Valvulus & redundancy,</u> <u>Arterioscl. hypertensive C.V.D.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>DUE TO (c)</u>			INTERVAL BETWEEN ONSET AND DEATH
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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>9/1/62</u> to <u>10/8/62</u> and last saw her alive on <u>10/8/62</u> Death occurred at <u>12:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Dr. Bernard Friedman, M.D.</u>		22b. ADDRESS <u>Koch Hospital Mo.</u>	
22c. DATE SIGNED <u>10/8/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 10, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OUR REDEEMER CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO.</u>
24. FUNERAL DIRECTOR <u>KRIEGSHAUSER 4228 S. KINGSHIGHWAY BLVD.</u>		25. DATE RECD. BY LOCAL REG. <u>10-9-62</u>	26. REGISTRAR'S SIGNATURE <u>J. M. Murphy, M.D.</u>

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 Ernest W. Fillard
Licensed Embalmer No. 4080

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.