

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045201

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3282

FILED NOV 16 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 4000  
2 4000  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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>CONCORD VILLAGE</u>		c. CITY OR TOWN <u>CONCORD VILLAGE</u>	
Length of stay in 1b <u>YRS.</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>11405 TESSON FERRY RD</u>		d. STREET ADDRESS (If outside, give location) <u>11405 TESSON FERRY RD</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>F.</u> Last <u>PRECELIUS</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-27-1879</u>
9. AGE (last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (City and state or country) <u>HEFFTON Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN PRECELIUS</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET SCHNETZ</u>	
14. NAME OF HUSBAND OR WIFE <u>CHARA PRECELIUS</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>NIL</u>		17. INFORMANT <u>CHARA PRECELIUS</u> Address <u>11405 TESSON FERRY RD ST LOUIS 29 MO</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>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 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 <u></u> a.m. <u></u> p.m. <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 COUNTY STATE
21. I attended the deceased from <u>November 1959</u> to <u>November 7 1962</u> and last saw him alive on <u>Nov. 6 1962</u> Death occurred at <u>3</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert M. Tichauer M.D.</u>		22b. ADDRESS <u>P.O. Box 8568 St Louis 26 Mo</u>	22c. DATE SIGNED <u>Nov 11-8-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov-9-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST JOHNS Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>MEHLVILLE Mo</u>
24. FUNERAL DIRECTOR <u>Fey Funeral Home, MEHLVILLE Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-9-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. [Signature]</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

*Gustav W. Dietrich*

Licensed Embalmer No.

*4329*

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.