

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048303

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12264

FILED JAN 2 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

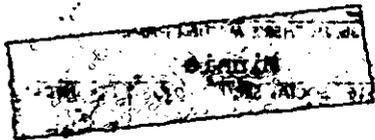
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DOCUMENT

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 | | | |
| | | St. Louis, Mo. | | 9 mo. | | c. CITY OR TOWN | | St. Louis | | | |
| | | c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | Inside Limits | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm | | | |
| | | St. Louis State Hosp. | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | 8721 Halls Ferry Rd. | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | | First Middle Last | | | 4. DATE OF DEATH | | | Month Day Year | | |
| | | | Elsie Ehmler | | | | | | Dec. 20, 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 | | | | 1-2-1888 | | 74 | | 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 | | | | | | | | St. Charles, Mo. | | America | |
| 13a. FATHER'S NAME | | | | 13b. MOTHER'S MAIDEN NAME | | | | 14. NAME OF HUSBAND OR WIFE | | | |
| Charles H. Meyer | | | | Minnie | | | | Henry | | | |
| 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. (If informant) | | | | 17. ADDRESS | | | |
| no | | | | | | | | 628 Washington St. St. Charles, Missouri | | | |
| 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. | | | | | | | | | | | |
| DUE TO (b) | | | | | | | | | | | |
| Diabetes Mellitus | | | | | | | | | | | |
| DUE TO (c) | | | | | | | | | | 260X | |
| 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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>Feb. 28, 1962</u> to <u>Dec. 20, 1962</u> and last saw her/him alive on <u>Dec. 20, 1962</u> Death occurred at <u>10:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. <u>Edward G. Dewein, M.D.</u> (Degree or title) | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | 22b. ADDRESS | | | 22c. DATE SIGNED | | | |
| <u>Edward G. Dewein M.D.</u> | | | | | <u>5400 Arsenal St.</u> | | | <u>12/21/62</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town, or county) (State) | | | | |
| Removal | | 12-23-1962 | | Trinity Lutheran Cemetery Orchard Farm, Missouri | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | | |
| <u>Arthur C. Baue</u> | | | | <u>St. Charles, Missouri</u> | | <u>DEC 21 1962</u> | | <u>Ed Smith, 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 Not In Embalmer's Power
Arthur C. Baul Funeral Home
620 Jefferson
St. Charles, Mo.
Licensed Embalmer No. _____
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.

S. 1/27/25