

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048424

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12618 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

<p>FILED JAN 10 1963</p>			
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>St. Louis</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u></p>	
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u></p>		<p>c. CITY OR TOWN <u>St. Lemay's</u></p>	
<p>c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Alexian Brothers</u></p>		<p>d. STREET ADDRESS (If outside, give location) <u>8715 S. Grand Ave</u></p>	
<p>3. NAME OF DECEASED First Middle Last <u>Carolyn Holtgreve</u></p>		<p>4. DATE OF DEATH <u>12-30-1962</u> Month Day Year</p>	
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>White</u></p>	
<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>10-6-1884</u> AGE (last birthday) <u>78</u> Yrs</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u></p>	
<p>11a. BIRTHPLACE (City and state or country) <u>Columbia Illinois</u></p>		<p>11b. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>	
<p>13a. FATHER'S NAME <u>Peter Mees</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Unknown</u></p>	
<p>14. NAME OF HUSBAND OR WIFE <u>William X. Holtgreve</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u></p>	
<p>16. SOCIAL SECURITY NO. <u>None</u></p>		<p>17. INFORMANT <u>William X. Holtgreve</u> Address <u>8715 S. Grand Av</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Carcinoma - Primary of Stomach</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u></p> <p>DUE TO (c) <u>151x</u></p>			<p>INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 months</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>			<p>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</p>
<p>19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p>20c. TIME OF INJURY Hour Month, Day, Year</p>			
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>			
<p>21. I attended the deceased from <u>1/26/62</u> to <u>12/30/62</u> and last saw her alive on <u>12/30/62</u> Death occurred at <u>9:00</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE (Degree or title) <u>Mitchell B. Butwick M.D.</u></p>		<p>22b. ADDRESS <u>7615 So Broadway</u></p>	
<p>22c. DATE SIGNED <u>12/31/62</u></p>		<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u></p>	
<p>23b. DATE <u>1-2-1963</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u></p>	
<p>23d. LOCATION (City, town, or county) (State) <u>Lemay (23) Mo Mo</u></p>		<p>24. FUNERAL DIRECTOR ADDRESS <u>Fendler Und. Co 7420 Michigan Av</u></p>	
<p>25. DATE RECD. BY LOCAL REG. <u>(11) DEC 31 1962</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u></p>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DATE AMENDED

MEDICAL CERTIFICATION BY AFFIDAVIT OF Fundal Director

DOCUMENT 10-6-84 + 78 1-14-63

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765 S. Broadway
FL 2-3706
JAMES
1981
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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. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Michigan

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.