

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048923

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 3679 STATE FILE NUMBER

FILED JAN 10 1963

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; 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>Overland</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>Overland</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>9727 Lackland Rd.,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>9727 Lackland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Louisa</u> Middle <u>R</u> Last <u>Briner</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1882</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>		11. BIRTHPLACE (City and state or country) <u>Clayton, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Phillip Litzinger</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Schmittel</u>		14. NAME OF HUSBAND OR WIFE <u>Rudolph (dcd).</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>Florence Briner-9727 Lackland Ave.,</u> Address <u>Overland 14</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>Cardiac Failure</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>	<u>Several years</u>
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.
 Yes No 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 checked="" 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 1929 to Dec. 15, 1962 and last saw her live on Dec. 6, 1962
Death occurred at 10:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Benjamin H. Mack, Jr.</u> (Degree or title)	22b. ADDRESS <u>3720 Washington - St. Louis</u>	22c. DATE SIGNED <u>Dec. 15, 1962</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12 18 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Ev. Cemetery Olivette, Mo.</u>	23d. LOCATION (City, town, or county) <u>Olivette, Mo.</u> (State)
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24. FUNERAL HOME <u>BAUMANN BROS. INC. FUNERAL HOME</u> <u>2504 WOODSON ROAD</u>		25. DATE RECD. BY LOCAL REG. <u>12-17-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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OVERLAND 14, MISSOURI

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

VS 300 Rev. 4/59
1 <u>400x</u>
2 <u>400x</u>
3 <u>2</u>
4 <u>1</u>
5 <u>2</u>
6
7 <u>0</u>
8 <u>2</u>
9 <u>4200</u>
10
11
12 <u>90-0</u>
13

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

David C. Libroni

Licensed Embalmer No. 3454

P. O. Address St. L. 1 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.