

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

589-63-004227
STATE FILE NUMBER

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

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u> | | c. CITY OR TOWN <u>ST. LOUIS</u> | |
| Length of stay in 1b | | d. STREET ADDRESS (If outside, give location) <u>1216 1/2 VICTOR</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ALEXIAN BROS. HOSP.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>AGNES M. URSCHLER</u> | | 4. DATE OF DEATH Month Day Year <u>JAN 17 1963</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>2-5-1902</u> |
| 9. AGE (last birthday) <u>60</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SUNSHINE BISCUIT</u> | 11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>FRANK BRINDA</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>CHARLES URSCHLER (DECD)</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u> | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT <u>CHARLES URSCHLER 4941 1/2 PERNO</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage;</u> <u>Atherosclerosis.</u> DUE TO (b) <u>331x</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | 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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Helen L. Taylor Coroner</u> | | 22b. ADDRESS <u>1300 Clark Ave.</u> | |
| 22c. DATE SIGNED <u>1-18-63</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 23b. DATE <u>JAN 21, 1963</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co. MO.</u> | |
| 24. FUNERAL DIRECTOR <u>Thomas Ratis</u> | | ADDRESS <u>2906 Gravois</u> | |
| 25. DATE RECD. BY LOCAL REG. <u>JAN 19 1963</u> | | 26. REGISTRAR'S SIGNATURE <u>Road Smith M.D.</u> | |

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Cover Case

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 *Loely Hays*

Licensed Embalmer No. *4861*

P. O. Address *St. Louis 19, 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.