

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004613

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 179

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JAN 25 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lemay</b>		c. CITY OR TOWN <b>Lemay</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>819 Reed ave.</b>		d. STREET ADDRESS (If outside, give location) <b>759 Pardella ave.</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helena</b> Middle <b>--</b> Last <b>Ochsner</b>			4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-5-1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (last birthday) <b>74</b>
11a. FATHER'S NAME <b>Unknown Appenzeller</b>		11b. MOTHER'S MAIDEN NAME <b>Unknown</b>	11c. BIRTHPLACE (City and state or country) <b>Switzerland</b>
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		12b. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13. NAME OF HUSBAND OR WIFE <b>Christian</b>		14. NAME OF HUSBAND OR WIFE <b>Christian</b>	
15. SOCIAL SECURITY NO. [ ]		16. INFORMANT Address <b>Mrs. Elsie Bingesser 819 Reed ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac. dilatation of heart</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 Mins.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>generalized arteriosclerosis</b>			<b>arterio-sclerotic heart disease</b>
DUE TO (c)			<b>several years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus</b>			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
h. cerebral hemorrhage			
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 <input type="checkbox"/> 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 <b>1950</b> to <b>1-15-63</b> and last saw her/him alive on <b>1-15-63</b> Death occurred at <b>9:20 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Eileen S. Scullius</b> (Degree or title)		22b. ADDRESS <b>752 Parkway Ferry Rd</b>	22c. DATE SIGNED <b>1-16-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-18-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>1215 Lemay Ferry Rd. Lemay, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>C. Hoffmeister Mortuaries 7814 S. Broadway</b>		25. DATE RECD. BY LOCAL REG. <b>1-17-63</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy</b>

NOT A PUBLIC RECORD

**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

*John LaDennedy*

Licensed Embalmer No. 4194

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.

Dr. Crecelius

12-2-30 8mm