

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017549

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4094 STATE FILE NUMBER

FILED APR 23 1963

DO NOT WRITE ON THIS STUD  
 AMENDED  
 VS 300 Rev. 4/59  
 1  
 2 220  
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 4 0  
 5 1  
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 12 90-3  
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 90  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ  
 USE BLACK INK OR TYPEWRITER RIBBON

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY                                       |  |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>   |   | Length of stay in 1b  | c. CITY OR TOWN <u>St. Louis</u><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>2162 S Bremen</u>   |   | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><u>2162 S Bremen</u><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>            |
| 3. NAME OF DECEASED (Type or print)<br>First <u>HENRY</u> Middle <u>A</u> Last <u>DERLETH</u>   |   |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>10</u> Year <u>1963</u>  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-5-1897</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Operator</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Valley Furn. Co</u>   | 11. BIRTHPLACE (City and state or country)<br><u>St. Louis, Mo</u>   |
| 13a. FATHER'S NAME<br><u>Henry Derleth</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Anna Nettlebush</u>   | 14. NAME OF HUSBAND OR WIFE<br><u>Clara Derleth</u>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |   | 17. INFORMANT Address<br><u>Clara Derleth - 2162 S Bremen</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO (b) <u>Atherosclerosis</u><br>DUE TO (c) <u>420.1</u><br>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.)<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ Month, Day, Year _____<br>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 _____<br>Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Joseph M. Jurem</u>  |   | 22b. ADDRESS<br><u>1300 Clark</u>   | 22c. DATE SIGNED<br><u>4-12-63</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>4-13-1963</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Calydr. Cemetery</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis Mo</u>   |
| 24. FUNERAL DIRECTOR<br><u>Edw Koch + Son</u>   |   | ADDRESS<br><u>3576 N 14th</u>   | 25. DATE RECD. BY LOCAL REG.<br><u>APR 12 1963</u>   |
|   |   |   | 26. REGISTRAR'S SIGNATURE<br><u>W. J. 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

*Yau M. Seymour*

Licensed Embalmer No.

*4343*

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.