

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-021652

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4929**

STATE FILE NUMBER

FILED MAY 17 1963

| | |
|---------------------|-------------------------|
| VS 300 Rev. 4/59 | AMENDED DATE AMENDED |
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |
| 10 | |
| 11 | |
| 12 | |
| 13 | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | Length of stay in 1b 4 1/2 months | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Edgewater Nursing Home | | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS 5446 Morganford | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MYRTLE L HAENEL | | | 4. DATE OF DEATH Month May Day 5 Year 1963 | | 5. SEX female | | 6. COLOR OR RACE white | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | |
| 8. DATE OF BIRTH 7/14/1898 | | 9. AGE (last birthday) 64 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Henry May | | | | 13b. MOTHER'S MAIDEN NAME Caroline Mehl | | | | 14. NAME OF HUSBAND OR WIFE William R. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address William R Haenel 5446 Morganford | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left Breast | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 170X | | | | | | | | | | | |
| 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. <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. | | Month, Day, Year | | | | | | | | | |
| 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 Dec. 13, 1962 to April 4, 1963 and last saw her ^{him} alive on April 4, 1963 Death occurred at 4:30 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE <i>Robert J. Sanders, M.D.</i> (Degree or title) | | | | | | 22b. ADDRESS 5502 Broadway | | | 22c. DATE SIGNED 4-6-63 (State) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 5/8/1963 | | 23c. NAME OF CEMETERY OR CREMATORY New St Marcus Cemetery | | 23d. LOCATION (City, town, or county) St. Louis County, Mo. | | | | | |
| 24. FUNERAL DIRECTOR John L Ziegenhein & Sons 7027 Gravois | | | | 25. DATE RECD. BY LOCAL REG. MAY 7 1963 | | 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> | | | | | |

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 E. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.