

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029576

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 590

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ST. CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. CHARLES		Length of stay in 1b 7 YEARS	c. CITY OR TOWN WASHINGTON
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION EVANGELICAL EMMAUS HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) JOHANNA SADINA FOERSTER			4. DATE OF DEATH Month AUGUST Day 4 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 28, 1882 - 80	9. AGE (last birthday) 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) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME FERDINAND FOERSTER		13b. MOTHER'S MAIDEN NAME JOSEPHINE ALTHEIDE		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, NO. (unknown)) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Joseph Storken, ST. CHARLES, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis		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 <u>1962</u> to <u>1962</u> and last saw her <u>alive</u> on <u>August 2, 1963</u> Death occurred at <u>6 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE W.H. Pogreben MD	(Degree or title)	22b. ADDRESS St Charles, Mo	22c. DATE SIGNED August 4, 1963
---	-------------------	---------------------------------------	---

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 8-6-1963	23c. NAME OF CEMETERY OR CREMATORY ST. PETER'S CEMETERY WASHINGTON, Mo.	23d. LOCATION (City, town, or county)
---	------------------------------	---	---------------------------------------

24. FUNERAL DIRECTOR HENRY W. OTTO WASHINGTON, MO.	ADDRESS	25. DATE RECD. BY LOCAL REG. Aug 4 - 1963	26. REGISTRAR'S SIGNATURE Mabel Zimmert Dep
--	---------	---	---

VS 300
Rev. 4/59

10928
20365

3
4 1
5 0
6
7 0
8 2
9493X

10
11
1286-0
13 50

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

AUG 12 1963

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 Connie L. Pickering

Licensed Embalmer No. 5789

P. O. Address: St. Charles, 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.