

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030700

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2163 STATE FILE NUMBER

**FILED JUL 22 1963**

DO NOT WRITE ON THIS STUB

AMENDED

|                     |  |  |
|---------------------|--|--|
| VS 300<br>Rev. 4/59 | DATE AMENDED                             |  |
| 4005                | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS |  |
| 24019               | INSTEAD OF                               |  |
| 3                   | DOCUMENT                                 |  |
| 4 0                 | MEDICAL CERTIFICATION                    |  |
| 5 1                 | SHOULD READ                              |  |
| 6                   | BY AFFIDAVIT OF                          |  |
| 7 0                 |  |  |
| 8 2                 |  |  |
| 9 331X              |  |  |
| 10                  |  |  |
| 11                  |  |  |
| 12 46-0             |  |  |
| 13                  |  |  |

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>                     |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>  |   | Length of stay in 1b <b>3 Days</b>  | c. CITY OR TOWN <b>Creve Coeur</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Marys Hospital</b>  |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS <b>#1 Country Fair Acres</b> (If outside, give location) Reside on Farm. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) <b>Ben Altheimer, Sr.</b>   |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>5</b> Year <b>1963</b>  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>12-28-77</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Broker</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>  | 9. AGE (last birthday) <b>85</b>   |
| 11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>   |   | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME <b>Saul Altheimer</b>   |   | 13b. MOTHER'S MAIDEN NAME <b>Mariam Simmons</b>   |  |
| 14. NAME OF HUSBAND OR WIFE <b>Myrtle Altheimer</b>  |   | 17. INFORMANT <b>Mrs. Ben Altheimer, Country Fair Acres #1</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>[REDACTED]</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |   |   |  |
| IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>   |   | INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>   |  |
| DUE TO (b) <b>Cerebral thrombosis</b>  |   | <b>13 days</b>  |  |
| DUE TO (c) <b>Cerebral arteriosclerosis</b>  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>arteriosclerosis Heart Disease, Congestive Failure</b>  |   |   |  |
| PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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<br>Hour <b>[REDACTED]</b> a.m. <b>[REDACTED]</b> 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 <b>Creve Coeur</b> COUNTY <b>Mo.</b> STATE <b>Mo.</b>   |
| 21. I attended the deceased from <b>June 22 1963</b> to <b>July 5, 1963</b> and last saw him alive on <b>July 5 1963</b><br>Death occurred at <b>1 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE (Degree or title) <b>James C. Redington M.D.</b>  |   | 22b. ADDRESS <b>Clayton Mo 950 Francis Place</b>  | 22c. DATE SIGNED <b>7-6-63</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>   | 23b. DATE <b>7-8-63</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>  | 23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b> (State)   |
| 24. FUNERAL DIRECTOR <b>Drehmann-Harral, 1905 Union Blvd.</b>  | ADDRESS <b>[REDACTED]</b>   | 25. DATE RECD. BY LOCAL REG. <b>7-6-63</b>  | 26. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |

USE BLACK INK OR TYPEWRITER RIBBON

Dr. James C. Redington  
950 Francis Place  
Hrs. 8:30-2 Sat.

**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 Albert R. Thompson

Licensed Embalmer No. 4237

P. O. Address H. J. [unclear]

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.