

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3205

State File No.

FILED JAN 28 1953

318

1003

Registrar's No. 0222

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, 2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL		d. STREET ADDRESS (If rural, give location) 5330 PERSHING AVE. 12	
3. NAME OF DECEASED (Type or Print) a. (First) LULA b. (Middle) MAE STAILEY c. (Last) HEIMBUECHER.		4. DATE OF DEATH (Month) (Day) (Year) Jan. 8, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 22, 1875
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frazier Stailey.	
13b. MOTHER'S MAIDEN NAME Emma Shoemaker.		14. NAME OF HUSBAND OR WIFE William C. Heimbuecher.	
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. None	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS William C. Heimbuecher; St. Louis, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Essential hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arterio sclerosis	
INTERVAL BETWEEN ONSET AND DEATH 15 hours 20 years many years		19a. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331 X	
22. I hereby certify that I attended the deceased from October, 1933 , to Jan 8, 1953 , that I last saw the deceased alive on Jan 8, 1953 , and that death occurred at 12:30 p. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) H. J. Newman M.D.		23b. ADDRESS 3720 Washington.	
23c. DATE SIGNED 1-8-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 1-10-1953		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons; 7233 Delmar Blvd.	
DATE REC'D BY LOCAL REG. JAN 9 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Yes No

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
Student Embalmer

Signed Arnold W. Schoene

Licensed Embalmer No. 3864

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 this body is not embalmed, fact should be so stated above.