

FILED OCT 24 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35068**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9147**

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis Mo</u>                                    |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u><br>b. COUNTY _____ |   |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> |  | c. CITY OR TOWN <u>St. Louis</u>   | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) _____   |  | e. STREET ADDRESS (If rural, give location) <u>15 4253 Neosho St.</u>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Pacific Hospital</u>                   |  |  |   |

|  |                  |                   |                           |  |
|--|------------------|-------------------|---------------------------|--|
| 3. NAME OF DECEASED (Type or Print) <u>Mrs Ida</u> | a. (First) _____ | b. (Middle) _____ | c. (Last) <u>Pfneisel</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 20 1955</u> |
|--|------------------|-------------------|---------------------------|--|

|                      |                               |   |                                       |   |   |                                       |
|----------------------|-------------------------------|---|---------------------------------------|---|---|---------------------------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Dec - 2, 1888</u> | 9. AGE (In years last birthday) <u>66</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 1 HR. Hours _____ Min. _____ |
|----------------------|-------------------------------|---|---------------------------------------|---|---|---------------------------------------|

|   |  |   |   |
|---|--|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> |
|---|--|---|---|

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME <u>Herman Meinhardt</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>John Pfneisel</u> |
|--|--|--|

|   |  |   |                            |
|---|--|---|----------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Otto E. Pfneisel-Webster</u> | ADDRESS <u>Groves, Mo.</u> |
|---|--|---|----------------------------|

|   |   |  |                                  |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage lt</u>  |  | <u>7 days</u>                    |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertension</u><br>DUE TO (c) _____ |  | <u>Unk.</u>                      |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>  |   |  | <u>7 days</u>                    |

|                              |  |  |
|------------------------------|--|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION <u>331x</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____ | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |
|---|--|----------------------------------|

22. I hereby certify that I attended the deceased from Oct-13, 1955, to Oct-20, 1955, that I last saw the deceased alive on Oct-20, 1955, and that death occurred at 1:10 p.m., from the causes and on the date stated above.

|   |                         |  |                                  |
|---|-------------------------|--|----------------------------------|
| 23a. SIGNATURE <u>Edmund R. Sheridan M.D.</u> | (Degree or title) _____ | 23b. ADDRESS <u>#16 Hampton Valley Plaza</u> | 23c. DATE SIGNED <u>10-20-55</u> |
|---|-------------------------|--|----------------------------------|

|   |                                |   |  |
|---|--------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Oct. 22, 1955</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u> |
|---|--------------------------------|---|--|

|   |  |   |                                   |
|---|--|---|-----------------------------------|
| DATE REC'D BY LOCAL REG. <u>OCT 20 1955</u> | REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wacker-Sellerle</u> | ADDRESS <u>-3634 Gravois Ave.</u> |
|---|--|---|-----------------------------------|

J.P. (Licensed Embalmer's Statement on Reverse Side)

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

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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.....



Licensed Embalmer No.....  
P. O. Address.....

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.