

FILED DEC 20 1956

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

42633

STATE FILE NUMBER

318

1003

10521

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Affton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital			Length of stay in lb 69 Yrs	d. STREET ADDRESS (If outside, give location) 9909 Affton Place			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FRED Middle HENRY Last AUFDERHEIDE				4. DATE OF DEATH Month Nov. Day 16, Year 1956			
5. SEX male	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 July 27, 1887		9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) postal clerk	10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 24 HRS. Hours _____ Min. _____	
13. FATHER'S NAME Edward H. Aufderheide				14. MOTHER'S MAIDEN NAME Mary Albus			
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 Mrs. Barbara M. Aufderheide, 9909 Affton Pl			
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 Chronic Sclerotic Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 420.0A						INTERVAL BETWEEN ONSET AND DEATH 7 days unk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old Chronic Pulmonary Tuberculosis, Arrested						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 _____ Month; Day, Year _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) ---					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION ---		COUNTRY ---		STATE ---	
21. I attended the deceased from Nov 9-1956 to Nov 16-56 and last saw her/him alive on Nov 16-56 . Death occurred at 12:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Robert E. Wagner M.D.				22b. ADDRESS 1115 Paul Bonn Bldg. MO		22c. DATE SIGNED Nov 17-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Nov. 19, 1956	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC. 1936 St. Louis Ave				25. DATE RECD. BY LOCAL REG. NOV 19 1956		26. REGISTRAR'S SIGNATURE Paul Smith MO	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner must use only standard numerals for the symptoms and diseases in Part I must be casually related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

000-56

Dr. Robert Warner M.D.
Christian Hospital

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 *Delia J. Krupp*

Licensed Embalmer No. *31*

P. O. Address *St. Jo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.