

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38795

STATE FILE NUMBER

FILED OCT 21 1957

Registration District No. 312 Primary Registration District No. 500 Registrar's No. 2440

Health, & Welfare Public Health Service

S. 300 400
1-56 0

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY SAINT LOUIS				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 NORMANDY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN NORMANDY 4000		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4701 NELSON DRIVE			Length of stay in lb 8 years		d. STREET ADDRESS (If outside, give location) 4701 NELSON DRIVE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CLARENCE Middle WILLIAM Last VONDERHEID				4. DATE OF DEATH Month OCT. Day 3 Year 1957					
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 MARCH 10, 1895		9. AGE (In years last birthday) 62 yrs IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary			10b. KIND OF BUSINESS OR INDUSTRY Prtg. Press. Union		11. BIRTHPLACE (City and state or country) Hecker, Illinois		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Vonderheid				14. MOTHER'S MAIDEN NAME Katherine Ballheimer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War 1			16. SOCIAL SECURITY NO. 492-01-2420		17. INFORMANT Mrs. Grace Vonderheid, 4701 Nelson Dr. 20			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca. of lung (bronchogenic) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 162X							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr Bronchitis							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 _____ Month _____ Day _____ Year _____ a. m. _____ 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		COUNTY		STATE	
21. I attended the deceased from Nov 56 , to Oct 3 57 and last saw her alive on Oct 3 Death occurred at 9:25 A m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE W D Conroy (Degree or title)				22b. ADDRESS W D O 495-2 Mapleland			22c. DATE SIGNED 10-3-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 5, 1957		23c. NAME OF CEMETERY OR CREMATORY NEW BETHLEHEM CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MISSOURI.			
24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Nat'l. Bridge Blvd.				25. DATE RECD. BY LOCAL REG. 10-4-57		26. REGISTRAR'S SIGNATURE Herbert B. Dombke MD			

Dr. L.D. Cassidy,
4952 Maryland,
Fo. 7-8844

Hrs. 124:30 P.M.

File in County

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 *Ralph C. Funder*.....

Licensed Embalmer No. *427*

P. O. Address *St. Louis*

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.