

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38805

STATE FILE NUMBER

FILED OCT 16 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2347

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Robertson</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Robertson</u> <u>4000</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Eldon &amp; Midland</u>			Length of stay in lb <u>45 YEARS</u>		d. STREET ADDRESS (If outside, give location) <u>Eldon &amp; Midland</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>L</u> Last <u>Wlodarek</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>2</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22 1877</u>		9. AGE (In years last birthday) <u>80</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Albert Keevil</u>				14. MOTHER'S MAIDEN NAME <u>Susie Steele</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Robert Wlodarek Robertson</u> Address <u>Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypothyroidism. Anemia due to hypothyroidism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years.</u> <u>uncertain</u> <u>2</u>		
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 <u>5:30</u> Month <u>Sept</u> Day <u>23</u> Year <u>1957</u> a. m. <u>5:30</u> 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 <u>St Louis</u> COUNTY <u>St Louis</u> STATE <u>Mo</u>			
21. I attended the deceased from <u>1934</u> to <u>Sept 23, 1957</u> and last saw her alive on <u>Sept 4, 1957</u> Death occurred at <u>5:30</u> A. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>G. O. Brown M.D.</u> (Degree or title)				22b. ADDRESS <u>1325 S. Grand, St. Louis 4, Mo.</u>		22c. DATE SIGNED <u>9/23/57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>9/26/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City, town, or county) (State) <u>St Louis</u>			
24. FUNERAL DIRECTOR <u>Ortmann F Home</u> ADDRESS <u>9222 Lackland Overland Mo</u>				25. DATE RECD. BY LOCAL REG. <u>9-23-57</u>		25. REGISTRAR'S SIGNATURE <u>Herbert R. Dombke, MD</u>			

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

Securing the medical certification in the specific manner required by 193.140 MoRS 1949.

Health & Welfare Public Service

300 1-56

**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 *Al C. Ostmann* .....

Licensed Embalmer No. *347*

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.