

Health,  
& Welfare  
S. Public  
th Service

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v. -57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FILED DEC 20 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

46854

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2985

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Ferdinand Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Ferdinand TWP</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hwy 67 R#1 Box 325</u>		Length of stay in lb <u>8 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>Hwy 67 R#1 Box 325</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Minna</u> Middle <u>A</u> Last <u>Mockel</u>			4. DATE OF DEATH Month <u>November</u> Day <u>25th</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 27th, 1872</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>5</u> Min.
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>at home</u>	11. BIRTHPLACE (City and state or country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>--- GERMANY</u>
13a. FATHER'S NAME <u>A. Gruner</u>		13b. MOTHER'S MAIDEN NAME <u>not known</u>		14. NAME OF HUSBAND OR WIFE <u>Arno Mockel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Fritz Mockel, R#1 Box 325, Florissant, 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>myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerotic &amp; arteriosclerotic changes</u> DUE TO (c) <u>4/201</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>cardiac failure</u>					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 <u>        </u> Month, Day, Year a.m. <u>        </u> p.m. <u>        </u>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>11/22/57</u> to <u>11/22/57</u> and last saw her alive on <u>11/27/57</u> Death occurred at <u>6:10</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>C. Hulst</u> (Degree or title)		22b. ADDRESS <u>10011 Bellefontaine Rd. #11</u>		22c. DATE SIGNED <u>11/26/57</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>11/29/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem Lutheran Cemetery</u>	
		23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>			
24. FUNERAL DIRECTOR <u>DIEDRICH FUNERAL HOME, 8319 Hallsferry</u>			25. DATE RECD. BY LOCAL REG. <u>11-29 57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke MO</u>

(Licensed Embalmer's Statement on Reverse Side)

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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

*Oliver P. Salver*  
Licensed Embalmer No. 4074  
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.