

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020081
STATE FILE NUMBER

318

1003

Registrar's No. 5833

FILED JUN 13 1958

Registration District No.

Primary Registration District No.

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>25</i> OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital 0</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>2209 2150 Bremen</i>
3. NAME OF DECEASED (Type or print) First <i>Agnes</i> Middle Last <i>Rindler</i>			4. DATE OF DEATH Month <i>6</i> Day <i>4</i> Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-7-1875</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	11. BIRTHPLACE (City and state or country) <i>Austria 4</i>
10c. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <i>Michael Thorsitz</i>		13b. MOTHER'S MAIDEN NAME <i>Unknown</i>	14. NAME OF HUSBAND OR WIFE <i>Michael Rindler</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Marie Rindler - 2150 Bremen</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <i>cerebral anterior sclerosis</i> <i>Senility</i> <i>334XF</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Inter trochanteric fracture femur right</i>			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>2</i>
20a. ACCIDENT <input checked="" 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.) <i>Fell out of bed 4-28-58</i>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <i>4, 18, 58</i>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>20 Home</i>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>2150 Bremen St. Louis City Mo.</i>	
21. I attended the deceased from <i>June 5th, 58</i> to <i>June 5th, 58</i> and last saw her alive on <i>May 29th, 1958</i> Death occurred at <i>3:35 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Edwin J. Froehlich MD</i>		22b. ADDRESS <i>3635 No. Newstead</i>	22c. DATE SIGNED <i>6-7-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>6-6-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Edw. Koch & Son - 3516 N. 14th</i>		25. DATE RECD. BY LOCAL REG. <i>JUN 5 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Gustav W. Putter*
Licensed Embalmer No. *4329*
P. O. Address *St. Louis Mo.*

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.