Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-031096

STATE FILE NUMBER 7888

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED AUG 28 1958

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: ST.LOUIS,MO. — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. #1. — Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN: ST.LOUIS,MO. — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2629 ANN — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First EMMA Middle Last WEIDNER

4. DATE OF DEATH: Month JULY Day 15 Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: NOV. 6, 1872

9. AGE (In years ~~and months~~ if under 1 year, days): 85 — 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): UNKNOWN

10b. KIND OF BUSINESS OR INDUSTRY: UNKNOWN

11. BIRTHPLACE (City and state or country): ST.LOUIS,MO.

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: CHRISTIAN FEHL

13b. MOTHER'S MAIDEN NAME: ANN ELIZ FLOCKMER

14. NAME OF HUSBAND OR WIFE:

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.: UNKNOWN

17. INFORMANT: ST.LOUIS CITY HOSP.,#1. Address

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 causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Malnutrition

INTERVAL BETWEEN ONSET AND DEATH: one month

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 6/13/58, to 7/15/58 and last saw her/him alive on 7/15/58

Death occurred at 11:A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Gray F. Ortmeyer M.D.

22b. ADDRESS: 1515 LAFAYETTE AVE.

22c. DATE SIGNED: 7/15/58

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 8-30-58

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Cowland-Aker — ADDRESS: 4104 Manchester

25. DATE RECD. BY LOCAL REG.: AUG 14 '58

26. REGISTRAR'S SIGNATURE: Pearl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No.....

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.