Health, & Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 10 1958

58-034158
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9448

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 01 5301 Page Ave. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: New Madrid
c. CITY OR TOWN: 072 Portageville — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 31 405 West 4th St. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Wilhelmina Middle: Last: Drerup
4. DATE OF DEATH: Month: October Day: 1, Year: 1958

5. SEX: Female 1
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH: October 19, 1868
9. AGE (In years last birthday): 89 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Ottawa, Ohio 1
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: John Drerup

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Alphonse Frerup, Address: Union City, Tenn.

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): Cardio-vascular Disease with Hypertension — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): —
DUE TO (c): — 443x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): —
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 Oct. 21/57, to Oct 1/58 and last saw her/him alive on Sept 30/58.
Death occurred at 3:45PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Dr. Wm J Langan Jr M.D. 0
22b. ADDRESS: 5803 Plymouth Av.
22c. DATE SIGNED: Oct. 2/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10-1-58
23c. NAME OF CEMETERY OR CREMATORY: Local
23d. LOCATION (City, town, or county) (State): Portageville, Mo.

24. FUNERAL DIRECTOR: Albert H. Hoppe, ADDRESS: 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: OCT 2 '58
26. REGISTRAR'S SIGNATURE: J Carl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

OCT 17 1958

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 Lawrence O. Geeling

Licensed Embalmer No. 4979

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.