

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034763

STATE FILE NUMBER 3031

FILED OCT 3 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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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

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|--|----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN ST. LOUIS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION FAITH HOSPITAL | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) 2239 1714 ALLEN AVE | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE TIMPE | | | 4. DATE OF DEATH Month Day Year SEPT 16 1958 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOV 7. 1882 | 9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SHOE WORKER | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state of country) MISSOURI | | 12. CITIZEN OF WHAT COUNTRY? U-S-A |
| 13a. FATHER'S NAME BERNARD TIMPE | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | 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. 489-10-7013 | | 17. INFORMANT Address MINNIE GASTREICH 1714 ALLEN | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arterio sclerosis | | | | | |
| DUE TO (c) | | | | | |
| 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 <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |
| 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 Month, Day, Year a.m. p.m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE | |
| 21. I attended the deceased from 9-8-58 to 9-16-58 and last saw her/him alive on 9-16-58 Death occurred at 4:30 P. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Donald L. Ooster MD | | 22b. ADDRESS 730 HODIAMONT | | 22c. DATE SIGNED 9-18-58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL SEPT. 19 1958 | | 23b. DATE SEPT. 19 1958 | | 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION | |
| 23d. LOCATION (City, town, or county) ST. LOUIS MO | | 23e. LOCATION (City, town, or county) ST. LOUIS MO | | 23f. LOCATION (City, town, or county) ST. LOUIS MO | |
| 24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois | | 25. DATE RECD. BY LOCAL REG. SEP 18 58 | | 26. REGISTRAR'S SIGNATURE J. C. Smith MD | |

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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 *Samuel E. Hill*

Licensed Embalmer No. *4347*
P. O. Address *2906 Hoover*

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.