

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042071

State File No.

FILED DEC 1 1958

BIRTH NO.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 10940

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		a. STATE Mo.	
c. LENGTH OF STAY (In this place) 6 weeks		b. COUNTY St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 09 DePaul Hospital		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
		d. STREET ADDRESS (If rural, give location) 1091 6112 N. Broadway	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Emma	b. (Middle) Geisel	c. (Last) Parish	(Month) 11	(Day) - 12	(Year) 1958
5. SEX F	6. COLOR OR RACE 1 CAUC.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Apr. 20, 1885	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Albatt		13b. MOTHER'S MAIDEN NAME Augusta Hartwig		14. NAME OF HUSBAND OR WIFE Wester Parish	
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. none		17. INFORMANT'S SIGNATURE OR NAME Wester Parish	
				ADDRESS 6112 N. Broadway	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Hypertension arteriosclerosis Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 443X			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from July, 1957, to 11-12-58, 1958, that I last saw the deceased alive on 11-12, 1958, and that death occurred at 12:12 a.m., from the causes and on the date stated above.

23a. SIGNATURE <i>Wayne O. Smith</i>		(Degree or title) 0		23b. ADDRESS 100 No Euclid		23c. DATE SIGNED 11-13-58	
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 11/14/58		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
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DATE REC'D BY LOCAL REG. NOV 14 58		REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Buchholz Mortuary</i>		ADDRESS 5967 W. Florissant Ave.	
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WHILE PRINTING - USING UNFADING BLACK INK - MAKE A PERMANENT RECORD

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
Student Embalmer

Signed: *Walter Buchholz*

Licensed Embalmer No. *4551*

P. O. Address *St Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.