

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003874

STATE FILE NUMBER

FILED JAN 12 1959

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 44

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-57

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHMOND HEIGHTS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>WEBSTER GROVES</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY'S Hosp. DAYS</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>1117 ELM DRIVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle _____ Last <u>MOULT</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>2</u> Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 27 1899</u>		9. AGE (In years last birthday) <u>59</u> 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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>AUSTRIA HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>PETER GRAF</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>LEO MOULT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Name <u>LEO MOULT</u> Address <u>1117 ELM DRIVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, basal</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____					
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? <u>331X</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <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 <u>12-19-58</u> to <u>Jan 4, 1959</u> and last saw her alive on <u>Jan 4, 1959</u> Death occurred at <u>_____</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>C. J. Volmer M.D.</u>			22b. ADDRESS <u>5320 Big Bend</u>		22c. DATE SIGNED <u>1/5/59</u>
23. BURIAL OR REMOVAL (Specify) <u>REBURIAL</u>		23b. DATE <u>JAN 6 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo.</u>
24. GENERAL DIRECTOR <u>Thomas Dutta 2906 Travis</u>		25. DATE RECD. BY LOCAL REG. <u>1-5-59</u>		26. REGISTRAR'S SIGNATURE <u>Delbert R. Donker M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *James C. Hill*

Licensed Embalmer No. *4347*

P. O. Address *2506 Laurel*

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.