

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011692  
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 317 Primary Registration District No. 544 Registrar's No. 763

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
a. COUNTY		St. Louis		a. STATE		Mo. b. COUNTY		St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only)		Kirkwood		c. CITY OR TOWN		Maplewood 4534		Inside Limits			
OR TOWN		Kirkwood		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Length of stay in lb		d. STREET ADDRESS					
St. Joseph's Hosp				5 wks.		7114 South St. (If outside, give location)					
Reside on Farm				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				First		Middle		Last		4. DATE OF DEATH	
LILLIAN				M		WERNER		March 20th 1959		Month Day Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		March 31, 1894		64		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife		Home		St. Louis, Mo.		U.S.A.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Peter Schwartz				Mary Dohnke							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no				none		Albert G. Werner		7114 South St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u>											
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? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" 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 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 <u>2-10-59</u> to <u>3-20-1959</u> and last saw <u>her</u> alive on <u>3-20-1959</u> Death occurred at <u>St. Joseph Hosp 745</u> on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED		
<u>Charles E. Hoegemeyer M.D.</u>						<u>333 S. Kirkwood Rd, Kirkwood</u>			<u>3-21-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)				
Burial		Mar. 23, 1959		Resurrection Cem.			St. Louis, Mo.				
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
A.H. Bocklage 6536 Clayton Rd.				3-21-59		<u>John E. Murphy M.D.</u>					

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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  
by me, ~~by~~....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Elmer R. Padon*.....

Licensed Embalmer No. *4*

P. O. Address *H. J.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.