

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014616

STATE FILE NUMBER

23803

FILED MAY 6 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300

1-57

57

1

0

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. John's Hospital</i> | | Length of stay in lb | d. STREET ADDRESS (If outside, give location) <i>3639 Upton</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <i>ALMA</i> Middle <i>K</i> Last <i>ALFELD</i> | | | 4. DATE OF DEATH Month <i>APRIL</i> Day <i>15</i> Year <i>1959</i> | | |
|---|--|--|---|--|--|

| | | | | | | |
|-------------------------|----------------------------------|---|---|--|--------------------------------|--------------------------------|
| 5. SEX <i>FEMALE</i> | 6. COLOR OR RACE <i>WHITE</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>MARCH 27, 1888</i> | 9. AGE (In years last birthday) <i>76</i> | 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) <i>AT HOME</i> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo.</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
|---|-----------------------------------|---|--|

| | | |
|--|---|--|
| 13a. FATHER'S NAME <i>-----KIENLE</i> | 13b. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i> | 14. NAME OF HUSBAND OR WIFE <i>DECEASED</i> |
|--|---|--|

| | | |
|---|--|--|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | 16. SOCIAL SECURITY NO. <i>NONE</i> | 17. INFORMANT <i>ELMER ALFELD</i> Address <i>3639 Upton</i> |
|---|--|--|

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral anoxia</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Congestive Heart Failure</i> DUE TO (c) <i>Coronary Occlusion</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs</i> <i>2 1/2 hrs</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <i>Related to atherosclerosis</i> | | 19. WAS AUTOPSY PERFORMED? 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.) <i>4201</i> |
|---|---|

| | | | |
|---|---|--|---|
| 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 <i>March 29-59</i> to <i>April 15-59</i> and last saw ^{her} _{him} alive on <i>April 15-1959</i> Death occurred at <i>10:15P</i> on the date stated above; and to the best of my knowledge, from the causes stated. | 22a. SIGNATURE <i>W. Pranger M.D.</i> (Degree or title) | 22b. ADDRESS <i>4952 Maryland</i> | 22c. DATE SIGNED <i>4/16/59</i> |
|--|--|--------------------------------------|------------------------------------|

| | | | |
|---|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i> | 23b. DATE <i>4/18/1959</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL PARK</i> | 23d. LOCATION (City, town, or county) (State) <i>AFFTON, Mo.</i> |
|---|-------------------------------|---|---|

| | | |
|--|---|--|
| 24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN & SONS</i> ADDRESS <i>7027 Gravois</i> | 25. DATE RECD. BY LOCAL REG. <i>APR 17 '59</i> | 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> |
|--|---|--|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Donald Berry*

Licensed Embalmer No. *4863*

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.