

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018888  
STATE FILE NUMBER

FILED MAY 19 1959 Registration District No. 316 Primary Registration District No. - Registrar's No. 193

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> )	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Francois Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Unknown</b> Inside Limits <b>Unknown</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospt. #4</b>		Length of stay in lb <b>29y; 17 das.</b>	d. STREET ADDRESS (If outside, give location) <b>4000 (St. Louis County)</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>KATHERINE</b> Last <b>WESTERMANN</b>			4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years birthday) <b>80</b>
11. BIRTHPLACE (City and state or country) <b>St. Louis County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Jacob Westermann</b>		13b. MOTHER'S MAIDEN NAME <b>Rosenfelder</b>	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) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Records, State Hospital No. 4, Farmington, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion - - - - - instantaneous.</b> DUE TO (b) <b>Coronary Sclerosis - - - - - Unknown.</b> DUE TO (c) <b>4201F</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Psychosis with mental deficiency, and fractured rt. hip 3-17-59</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <b>Fell on ward of mental hospital.</b>	
20c. TIME OF INJURY <b>6:40 p.m.</b>		Month, Day, Year <b>3-17-59</b>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Ward of mental hospital</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>St. Francois Twp. St. Francois Mo.</b>
21. I attended the deceased from <b>April 28, 1959</b> to <b>May 8, 1959</b> and last saw her live on <b>May 8, 1959</b> Death occurred at <b>6:40 P. M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>J. L. Brenner, M.D.</b>		22b. ADDRESS <b>State Hospital No. 4 Farmington, Missouri</b>	22c. DATE SIGNED <b>5-8-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-13-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Univ. Anat. Dept.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Miller Funeral Home, Farmington, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>May 14, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Catherine Rudloff</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, Local, etc. 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 Her Embalmer....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Paul H. [Signature] .....

Licensed Embalmer No. 4170.....  
P. O. Address Farmington, Va.....

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.