

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022634

STATE FILE NUMBER

2-5484

FILED JUN 18 1959

Registration District No. _____ Primary Registration District No. _____

Registrar No. _____

S. 300

1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis			
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp		d. STREET ADDRESS (If outside, give location) 4245 West Pine			
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELSIE HELEN ADERTON			4. DATE OF DEATH Month Day Year June 6, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 20, 1920		
9. AGE (In years (irthday) 38		10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Office Clerk		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo		
12. CITIZEN OF WHAT COUNTRY? U S A		13a. FATHER'S NAME Frank Koenig			
13b. MOTHER'S MAIDEN NAME Elizabeth Sauer		14. NAME OF HUSBAND OR WIFE ----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 577-36-8920			
17. INFORMANT Address Frank Koenig 4439 Pennsylvania		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericarditis 2ndary to uremia with bloody effusion Lupus erythematosus with nephritis DUE TO (b) Lupus erythematosus & nephritis DUE TO (c) 705.4 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Renal failure		INTERVAL BETWEEN ONSET AND DEATH ~3 years	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 April 1959 to June 1959 and last saw her alive on June 6, 1959 Death occurred at 10:28 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Robert E. Cutler, M.D.		22b. ADDRESS Jewish Hosp.			
22c. DATE SIGNED 6/8/59		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			
23b. DATE June 9-1959		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.			
23d. LOCATION (City, town, or county) St Louis Co. Mo.		(State)			
24. FUNERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois		25. DATE RECD. BY LOCAL REG. JUN 9 '59			
26. REGISTRAR'S SIGNATURE Loard Smith, M.D.					

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. 4342
P. O. Address 2906 Dupont

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.