

MD DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026288

FILED VS JUL 27 1959

Registration District No. 10 Primary Registration District No. 3058 Registrar's No. 174

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY St. Charles			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Charles		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in 1b 11 yrs.	c. CITY OR TOWN St. Charles,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Colonial Rest Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Colonial Rest Home		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Anna Middle Last Pfarr			4. DATE OF DEATH Month July Day 18 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/14/64	9. AGE (last birthday) 94	IF UNDER 1 YEAR Months 11 Days 4 IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-keeper		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Weldon Springs, Mo.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William Pfarr		13b. MOTHER'S MAIDEN NAME Anna Lange		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Vernon Pfarr, W. Alton, Mo.		
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>acute myocardial infarct</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>generalized arteriosclerosis</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
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>January 6, 59</u> to <u>July 18, 59</u> and last saw her ^{her} _{him} alive on <u>July 17, 59</u> . Death occurred at <u>5 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>George E. Kistner M.D.</u> (Degree or title)			22b. ADDRESS <u>St Charles mo</u>		22c. DATE SIGNED <u>7-19-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/20/59	23c. NAME OF CEMETERY OR CREMATORY Weldon Springs Cemetery		23d. LOCATION (City, town, or county) (State) Weldon Springs, Mo.	
24. FUNERAL DIRECTOR Arthur C. Baue		ADDRESS St. Charles, Mo.	25. DATE RECD. BY LOCAL REG. July 19-59	26. REGISTRAR'S SIGNATURE <u>Arleene Wilson</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David C. Baul

Licensed Embalmer No. 5060

P. O. Address St. Charles

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.