RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 11 1959

2 8023 59-030829

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis,
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 4126 Minnesota Ave.,
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri, b. COUNTY
c. CITY OR TOWN: St. Louis,
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4126 Minnesota Ave.,
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Margaret Middle: A. Last: Nonnenkamp-Stoeckel
4. DATE OF DEATH: Month August Day 28 Year 1959
5. SEX: Female.
6. COLOR OR RACE: White,
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2/22/78
9. AGE (last birthday): 81
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home,
11. BIRTHPLACE (City and state or country): St. Louis, Missouri,
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Charles Ikemeyer,
13b. MOTHER'S MAIDEN NAME: Mathilda Preisinger
14. NAME OF HUSBAND OR WIFE: Andrew A. Stoeckel,
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Andrew A. Stoeckel, 4126 Minnesota Ave.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 10 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): CEREBRAL ARTERIOSCLEROSIS
DUE TO (c): SENILITY 332x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 FEB 1957, to AUG 1959 and last saw him/her alive on AUG 22, 1959
Death occurred at 3:00 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Gerald Hoffmann M.D. (Degree or title)
22b. ADDRESS: 6506 Chippewa
22c. DATE SIGNED: 8/29/59
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial,
23b. DATE: 8/31/59
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery,
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.
24. FUNERAL DIRECTOR: Gebken-Benz Mortuary, ADDRESS: 2842 Meramec St., St. Louis, 18, Mo.
25. DATE RECD. BY LOCAL REG.: AUG 29 '59
26. REGISTRAR'S SIGNATURE: Lead Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed V E Morris

Signature of Student Embalmer

Licensed Embalmer No. 336 C

P. O. Address St Louis

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