

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033444

FILED VS OCT 5 1959 310

Registration District No. _____ Primary Registration District No. 3058 Registrar's No. 233

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in lb 10 days	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 St. Joseph Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 404 Jefferson St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Carrie Middle J. Last Pfaff			4. DATE OF DEATH Month Sept. Day 27 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 Sept. 19, 1876	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months 0 Days 8 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing	11. BIRTHPLACE (City and state or country) Cottleville, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John Pfaff		13b. MOTHER'S MAIDEN NAME Katherine Mueller		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. 493-01-7687		17. INFORMANT Address Estella Pfaff, St. Charles, 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) Cerebro-vascular accident (thrombotic)			INTERVAL BETWEEN ONSET AND DEATH 2 hrs 5 yrs!
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerosis cerebral			
DUE TO (c)			
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. <input type="checkbox"/> Yes <input 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 May 1, 52 to 9-27-59 and last saw her alive on 9-27-59 Death occurred at 10:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) George E. Winters M.D.		22b. ADDRESS St Charles Mo	22c. DATE SIGNED 9-28-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 30, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Peter Cemetery	23d. LOCATION (City, town, or county) (State) St. Charles, Mo.
24. FUNERAL DIRECTOR ADDRESS H.C. Dallmeyer & Sons, St. Charles, Mo.		25. DATE RECD. BY LOCAL REG. Sept 29-59	26. REGISTRAR'S SIGNATURE Marcella Wilson

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1959 OCT 2 100

3981 8 :

APR 19 1960

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 Frank R. Amalson

Licensed Embalmer No. _____

P. O. Address _____

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.