

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-034196

### FILED VS OCT 5 1959

### 2 8733

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2534 Warren St.</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>2534 Warren St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>Mamie</b> Middle <b>M</b> Last <b>Porzelt</b>	<b>4. DATE OF DEATH</b> Month <b>9</b> Day <b>20</b> Year <b>59</b>
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<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>4/6/1887</b>	<b>9. AGE (last birthday)</b> <b>72</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis Mo.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
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<b>13a. FATHER'S NAME</b> <b>Jacob Gerst</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Catherine Rieth</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Louis Porzelt</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT</b> Address <b>Crescen</b> <b>Louis Porzelt 39 Plymouth Tr. Mo</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic Hypertension</b> DUE TO (c) <b>420.1</b>	INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>2 yr.</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Much overweight</b>	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
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
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21. I attended the deceased from **1957** to **9/20/59** and last saw her alive on **9-15-59**  
 Death occurred at **estimated 12:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <b>A. O. Beecher M.D.</b>	<b>22b. ADDRESS</b> <b>2505 North Thompson</b>	<b>22c. DATE SIGNED</b> <b>9/22/59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removed</b>	<b>23b. DATE</b> <b>9/24/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hiram Park Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Robert D. Kinealy 2228 St. Louis Ave.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>SEP 22 1959</b>	<b>26. REGISTRAR'S SIGNATURE.</b> <b>Earl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Dr. Pueler - Co. 1-17-12*  
*2500 S. 1st St.*

**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 *W E Morris*

Licensed Embalmer No. *3360*

P. O. Address *St Louis*

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.