

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042330

FILED VS NOV 20 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210417** STATE FILE NUMBER

NDED

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		Length of stay in 1b 4 da	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8640 Tara Lane Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First KATHERINE Middle ORT Last			4. DATE OF DEATH Month November Day 10th Year 1959		
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/27/95	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days 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, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Henry Heinen		13b. MOTHER'S MAIDEN NAME Katherine Stepenbrink		14. NAME OF HUSBAND OR WIFE Samuel Ort	

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 Samuel Ort, 8640 Tara Lane	Address
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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 hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.) 331x	
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.) 4	20f. CITY, TOWN, OR LOCATION St. Louis	COUNTY St. Louis Co.	STATE Mo.
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21. I attended the deceased from **Nov 6, 1959** to **Nov 10** and last saw her/him alive on **Nov 10, 1959**
Death occurred at **4:30 PM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Carl J. Heitzenroeder M.D.	22b. ADDRESS 3720 Washington	22c. DATE SIGNED 11-12-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 11/14/59	23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Emil J. Heitzenroeder, 8319 Hallsferry	ADDRESS	25. DATE RECD. BY LOCAL REG. NOV 12 1959	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.P.

Printed Name

City

State

County

Death Date

Age

Sex

Place of Birth

Education

Occupation

Religion

Marital Status

Cause of Death

Place of Death

Place of Burial

Time

Page

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 Elmo R. Padgett

Licensed Embalmer No. 407

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.