

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS. DEC 23 1959 77

Primary Registration District No. 3016

Registrar's No. 352

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY COLE				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 JEFFERSON CITY		Length of stay in 1b 6 YEARS		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 ST. JOSEPH HOME			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5956 LUCILLE AVENUE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH RENSING				4. DATE OF DEATH Month Day Year DECEMBER 18, 1959											
5. SEX female		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-16-1861		9. AGE (last birthday) 98		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY U.S.A.							
13a. FATHER'S NAME Wm - SCHLICH				13b. MOTHER'S MAIDEN NAME UNKNOWN				14. NAME OF HUSBAND OR WIFE DECEASED							
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. UNKNOWN		17. INFORMANT Address MR. FRED. C. SCHARPF 7810 FORSYTH-ST. L									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) Senility										INTERVAL BETWEEN ONSET AND DEATH					
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 Jan 5th 1957 to Dec 18-19 59 and last saw her/him alive on Dec 16-19 59 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE A. Resman MD (Degree or title)				22b. ADDRESS Jefferson City - Mo				22c. DATE SIGNED 12-18-59							
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 12-22-59		23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY				23d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI							
24. FUNERAL DIRECTOR Lyndon H. Kuhn ADDRESS J.C. Mo.				25. DATE RECD. BY LOCAL REG. 18 Dec. 1959		26. REGISTRAR'S SIGNATURE R.P. Davis MD - Whickler									

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

YS NOV 1 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. Asplund
P. O. Address _____
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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.