

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 046002

FILED VS. DEC 3 0 1959

211548

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis, Co.	
c. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 9808 Guthrie	

3. NAME OF DECEASED (Type or print) First William Middle H Last Surkamp, Sr.			4. DATE OF DEATH Month December Day 11 Year 1959		
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5. SEX Male	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 7/31/99	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Joseph J. Surkamp	13b. MOTHER'S MAIDEN NAME Matilda Bruescke	14. NAME OF HUSBAND OR WIFE Suzanne M. Surkamp
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I	16. SOCIAL SECURITY NO. 191-22-9107	17. INFORMANT Address Mrs Suzanne M. Surkamp 9808 Guthrie
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18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Septicemia		2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Nephrotic abscess of kidney	2 weeks
	DUE TO (c) stone right water	1 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hyperuricemia Cardio-vascular disease	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 602x
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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
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21. I attended the deceased from 3-17-56 to 12-11-59 and last saw her/him alive on 12-11-59
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22a. SIGNATURE Louis F. Home M.D.	22b. ADDRESS 9806 Harrison Boulevard 17 Mo	22c. DATE SIGNED 12-11-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/14/59	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co, Missouri
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24. FUNERAL DIRECTOR ADDRESS Oltman Funeral Home; Union, Mo	25. DATE RECD. BY LOCAL REG. DEC 14 1959	26. REGISTRAR'S SIGNATURE Keal Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Louis F. Howe
8806 Harrison
1 to 5:30 P.M.
Wo. 2-3521

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 Joseph E. McMillon

Licensed Embalmer No. 2460

P. O. Address 61758

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.