

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012072
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 573

FILED VS MAR 14 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Ferdinand Twp</u> Length of stay in lb <u>4 yr</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Villa Gesu</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>St. Ferdinand Twp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>11755 Riverview</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last <u>SISTER MARY MELANIA PASCHANG</u>	4. DATE OF DEATH Month Day Year <u>February 26th, 1961</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/28/74</u>	9. AGE (last birthday) <u>86</u>	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) <u>Teacher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>	11. BIRTHPLACE (City and state or country) <u>Rich Fountain, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Henry Paschang</u>	13b. MOTHER'S MAIDEN NAME <u>Teresa Kuensting</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Sister M Nicoletta, 11755 Riverview</u>
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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) <u>Acute bacterial meningitis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic gastric ulcer</u> DUE TO (c) <u>Hypertensive C.V. disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>10 yrs</u> <u>15 yrs</u>
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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). <u>Schist</u>	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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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 Sept 1960 to 2-26-61 and last saw her alive on 2-25-61
 Death occurred at 2:12 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. Weyand MD</u>	22b. ADDRESS <u>838 1/2 Broadway</u>	22c. DATE SIGNED <u>2-27-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>3/1/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Villa Gesu</u>	23d. LOCATION (City, town, county) (State) <u>St. Louis Co. Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Emil J. Heitzenroeder, 8319 Hallsferry</u>	25. DATE RECD. BY LOCAL REG. <u>2-28-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

State of Missouri

State of Missouri

Department of Health

Department of Health

X

Embalmer

X

Embalmer

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Name of physician

6. Name of funeral home

7. Name of embalmer

8. Sex

9. Age

10. Occupation

11. Name of next of kin

12. Address

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 Stanley H. Dixon

Licensed Embalmer No. 4193

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.

13. Name of funeral home

14. Address

15. City

16. State

17. Date of embalming