

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018697

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 210 Primary Registration District No. 3058 Registrar's No. 116

FILED MAY 16 1961

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		c. CITY OR TOWN <u>St. Charles</u>	
Length of stay in 1b <u>3 Yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1019 So. Main St.</u>		d. STREET ADDRESS (If outside, give location) <u>1019 So. Main St.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Pfeiffer</u> Last <u>Pfeiffer</u>	4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1961</u>
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5. SEX <u>Male</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>Jul. 3, 1887</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>2</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (City and state or country) <u>Portage des Sioux, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</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>	17. INFORMANT Address <u>Mr. Joseph Haake, St. Charles, Mo</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>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</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)	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 checked="" type="checkbox"/> NO <input 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 <u>11</u> 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 <u>St. Charles</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>
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21. I attended the deceased from 1959 to 1961 and last saw him alive on March 15, 1961
Death occurred at 7 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. H. Poggenier MD</u> (Degree or title)	22b. ADDRESS <u>St. Charles Mo</u>	22c. DATE SIGNED <u>May 10, 1961</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 8, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>	23d. LOCATION (City, town, or county) <u>Portage des Sioux, Mo.</u>
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24. FUNERAL DIRECTOR <u>H. C. Dallmeyer & Sons, St. Charles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 7-61</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

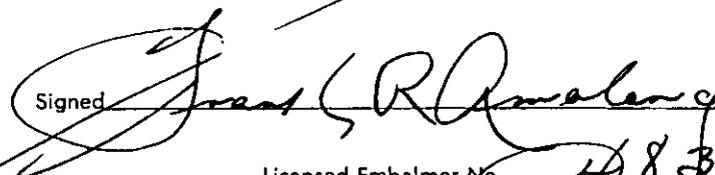
ITEM NO. SHOULD READ

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. 4830

P. O. Address St Charles

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.