

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035252

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2861 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Florissant</u>		Length of stay in 1b <u>3 yrs</u>	c. CITY OR TOWN <u>Florissant</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>19 Valley Dr.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>19 Valley Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Cornelia</u> Middle <u>Feldmeier</u> Last <u>Feldmeier</u>			4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>61</u>		
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/01</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Boding</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Noelker</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph Feldmeier</u>	
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>Joseph Feldmeier 19 Valley Dr.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Rheumatic heart disease with mitral stenosis, insufficiency & auricular fibrillation INTERVAL BETWEEN ONSET AND DEATH 45 yrs (5 mo)

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) Possible coronary embolus or pulmonary or cerebral embolus?

PART III. If deceased was female was there a pregnancy in last 90 days.  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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 checked="" 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 6-8-61 to 9-26-61 and last saw her alive on 9-26-61  
 Death occurred at 1:15P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John H. Ortman MD</u>	22b. ADDRESS <u>950 Francis Pl. Clayton 5 Mo</u>	22c. DATE SIGNED <u>10-10-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>
24. FUNERAL DIRECTOR ADDRESS <u>Ortmann F Home 9222 Lackland Overland 14</u>		23d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>

25. DATE RECD. BY LOCAL REG. <u>10-10-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
----------------------------------------------	------------------------------------------------------

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

**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 Al C Ortman

Licensed Embalmer No. 3478

P. O. Address \_\_\_\_\_

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.