

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-047156**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3526

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

**FILED DEC 21 1961**

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	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</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>HIGH TOWER NURSING HOME</u>		Length of stay in 1b <u>WKS.</u>	d. STREET ADDRESS (If outside, give location) <u>1420 E. Prairie Ave</u>
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>AMANDA</u> Middle <u>EMMERICK</u> Last			4. DATE OF DEATH Month <u>DEC.</u> Day <u>11</u> Year <u>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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-9-85</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days	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>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>WM. VOGELSANG</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA LENNINGRATH</u>	14. NAME OF HUSBAND OR WIFE <u>PETER EMMERICK</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 <u>MABEL TOENISKOETTER</u>	Address
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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>Right Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pulmonary Emphysema</u>		<u>unknown</u>
DUE TO (c) <u>Pulmonary Fibrosis</u>		<u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>527.1</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

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 <u>2:05 P</u> 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
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21. I attended the deceased from <u>Nov 2, 1961</u> to <u>Dec 11, 1961</u> and last saw her alive on <u>Dec 11, 1961</u>	
Death occurred at <u>2:05 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>Sever Litzmann MD</u> (Degree or title)	22b. ADDRESS <u>8231 Clayton Rd (17)</u>	22c. DATE SIGNED <u>12/12/61</u> (State)
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23a. BURIAL, CREMATION, REMOVAL Specify <u>BURIAL</u>	23b. DATE <u>11-14-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SALEM LUTHERAN CEM.</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS COUNTY MO.</u>
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24. FUNERAL DIRECTOR <u>STROOT CARROLL</u> ADDRESS <u>4600 NATURAL BRIDGE</u>	25. DATE RECD. BY LOCAL REG. <u>12-12-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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DR LEWIS E LITTMANN  
8231 CLAYTON RD.  
PAT - 0202

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still ✓ Book  
3 still ✓

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

*M W Rueter*

Licensed Embalmer No.

4865

P. O. Address

St Louis, M

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.