

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-004318

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **289**

STATE FILE NUMBER

FILED JAN 11 1962

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) St Louis				Length of stay in 1b		c. CITY OR TOWN St Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) Home				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3627 Bamberger Ave		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) Lady of Perpetual Help								
3. NAME OF DECEASED (Type or print) First Margareth Middle Mary Last Padberg				4. DATE OF DEATH Month Jan Day 7 Year 1962				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/13/71	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (City and state or country) St Louis Missouri		12. CITIZEN OF WHAT COUNTRY U S
13a. FATHER'S NAME Jacob Diefenbrunn				13b. MOTHER'S MAIDEN NAME Margaret		14. NAME OF HUSBAND OR WIFE Lorenz F. (Deceased)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 4421		17. INFORMANT Lawrence W Padberg 5648 Pernod Av		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac Cardiac Failure Arterio Sclerosis Heart Disease Ac Pulmonary Passive Congestion Cardio Renal Hypertension Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio Sclerosis Heart Disease DUE TO (c) Cardio Renal Hypertension								INTERVAL BETWEEN ONSET AND DEATH 1 day
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 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.) 4421				
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ s.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	
21. I attended the deceased from 10/3/57 to 1/7/62 and last saw her alive on 1/7/62 Death occurred at 3:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE George J. McHale MD (Degree or title)				22b. ADDRESS 3903 Olive		22c. DATE SIGNED 1/8/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/10/62	23c. NAME OF CEMETERY OR CREMATORY S S Peter & Paul Cem		23d. LOCATION (City, town, or county) St Louis Missouri.		(State)	
24. FUNERAL DIRECTOR Moydell Funeral Home 1926 Allen				25. DATE RECD. BY LOCAL REG. JAN 8 1962		26. REGISTRAR'S SIGNATURE Loal Smith, M.D.		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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 Madley JT Koeller Jr

Licensed Embalmer No. 4950

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.