

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008525  
STATE FILE NUMBER

318 / Primary Registration District No. 1003 Registrar's No. 1680

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**FILED FEB 23 1962**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY - - -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY - - -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b <b>1 month</b>	c. CITY OR TOWN <b>St. Louis, Missouri</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5818 Lindenwood</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Dora</b> Middle <b>Wilsberg</b> Last <b>Nielsen</b>			4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1962</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-21-1893</b>
9. AGE (last birthday) <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Chicago, Illinois</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>John Wilsberg</b>	
13b. MOTHER'S MAIDEN NAME <b>Emily Tuhus</b>		14. NAME OF HUSBAND OR WIFE <b>Walter I. Nielsen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Myrtle Trienens</b> Address <b>Wilmette, Ill. 10th Avenue</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease - Rheumatic</b> DUE TO (b) <b>Heart disease - Stoker Adams Syndrome</b> <b>Calcific aortic stenosis, Bicuspid aortic valve.</b> DUE TO (c) <b>4200</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Rheumatic ailment, old Subdural Hematoma.</b>			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 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.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 <b>1/9/62</b> to <b>2/8/62</b> and last saw her alive on <b>2/7/62</b> Death occurred at <b>9840 A</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert J. Ramsey, M.D.</b> (Degree or title)		22b. ADDRESS <b>25a5 Loumont, Ferguson, Mo</b>	
22c. DATE SIGNED <b>2/9/62</b> (State)		22d. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Rail</b>		23b. DATE <b>2-9-62</b>	
23c. LOCATION (City, town, or county) <b>Skokie, Illinois</b>		23d. FUNERAL DIRECTOR <b>HOFFMEISTER COLONIAL MORTUARY</b>	
24. FUNERAL DIRECTOR ADDRESS <b>HOFFMEISTER COLONIAL MORTUARY</b>		25. DATE RECD. BY LOCAL REG. <b>2-9-1962</b>	
26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b>			

Dr. Robert H. Ramsey  
25a S. Florissant Road  
JA 1 4-0560

### 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 Bill C. Branson

Licensed Embalmer No. 4764

P. O. Address St. Louis, Mo.

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.