

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

10133-62-040815
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10133**

FILED NOV 13 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

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY			
St. Louis		St. Louis				Missouri		St. Louis			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
St. Anthony Hospital						928 Erskine Avenue					
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year								
Clara L. Tischler			October 22, 1962								
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR				
Female	White		10/21/1900	62	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY				
Housework			Own Home		St. Louis, Missouri		U.S.A.				
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE					
August DeBuck			Stephanie (Unk.)			Clarence					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			None		Clarence Tischler 928 Erskine Lemay, Mo.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)				ACUTE LEFT VENTRICULAR FAILURE						INTERVAL BETWEEN ONSET AND DEATH, SUDDEN	
DUE TO (b)				HYPERTENSIVE HEART DIS.						7 YEARS.	
DUE TO (c)				443X							
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 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 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		COUNTY		STATE			
				APRIL 53		to Oct. 11, 1962		and last saw her alive on 11 OCT 62			
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ 5:10 A.M. _____ on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>C. Hoffmeister M.D.</i>				22b. ADDRESS 6500 CHESAPEWA		22c. DATE SIGNED 10/29/62					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)			
Removal		Oct. 24, 1962		Mt. Olive Cemetery		Lemay, Missouri					
24. FUNERAL DIRECTOR ADDRESS C. Hoffmeister Mortuaries 7814 So. Broadway St. Louis, Mo.				25. DATE RECD. BY LOCAL REG. OCT 23 1962		26. REGISTRAR'S SIGNATURE <i>Road Smith, M.D.</i>					

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 *Lina C. Hoffmann*

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.

Professor ~~Dr.~~ David Hoffmann
FL 1-2854
6500 Chipewa

Est. 8/6/12