

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013717

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2866** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FILED MAR 20 1963		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) OR TOWN 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) HOSPITAL OR INSTITUTION Lutheran Altenheim		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 8612 Hallsferry Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MATHILDA Middle A Last POSER			4. DATE OF DEATH Month March Day 11th Year 1963		
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/29/70	9. AGE (last birthday) 92	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and state or country) St. Charles, Mo.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Henry Suelthaus		13b. MOTHER'S MAIDEN NAME Marie Paackemeyer		14. NAME OF HUSBAND OR WIFE August Poser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates) no			17. INFORMANT Esther Wermeier, 926 Melvin		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Arteriosclerotic Heart Disease</i> DUE TO (b) _____ DUE TO (c) 420.0 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					INTERVAL BETWEEN ONSET AND DEATH 15 yrs
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.)			
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
21. I attended the deceased from 1947 to Mar 11 - 63 and last saw her/him alive on Mar 7 - 63 . Death occurred at 12:55 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>John R. Poser M.D.</i>			22b. ADDRESS 8054 S. Broadway		22c. DATE SIGNED 3/11/63
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 3/14/63	23c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran Cemetery		23d. LOCATION (City, town, County) (State) St. Charles, Mo.	
24. FUNERAL DIRECTOR EMIL J. HEITZENROEDER, 8319 Hallsferry			25. DATE RECD. BY LOCAL REG. MAR 12 1963	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH OFFICERS
CERTIFICATE OF EMBALMING

NO. _____

DATE _____

LOCALITY _____

DECEASED _____

AGE _____

SEX _____

CAUSE OF DEATH _____

PLACE OF DEATH _____

PLACE OF BURIAL _____

EMBALMER'S NAME _____

EMBALMER'S NO. _____

EMBALMER'S ADDRESS _____

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 Harvey Kable
x

Licensed Embalmer No. 4596

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.