

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021537

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6020**

STATE FILE NUMBER

FILED JUN 13 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY _____</p> <p>b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis</p> <p>c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis University Hosp.</p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE Mo. b. COUNTY _____</p> <p>c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) 4149a Botanical Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print)</p> <p>First SOPHIA Middle G. Last ENGELHART</p>	<p>4. DATE OF DEATH</p> <p>Month June Day 6 Year 1963</p>
<p>5. SEX Female</p> <p>6. COLOR OR RACE White</p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer (Retired) Blanke-Baer Preserve Co.</p> <p>13a. FATHER'S NAME George Janssen</p>	<p>7. Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH 12-4-1893</p> <p>9. AGE (last birthday) 69</p> <p>10b. KIND OF BUSINESS OR INDUSTRY _____</p> <p>11. BIRTHPLACE (City and state or country) St. Louis, Mo.</p> <p>12. CITIZEN OF WHAT COUNTRY U.S.A.</p> <p>13b. MOTHER'S MAIDEN NAME Sophia Sodabier</p> <p>14. NAME OF HUSBAND OR WIFE Otto W. Engelhart</p>
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No</p>	<p>17. INFORMANT Otto W. Engelhart 4149a Botanical Ave.</p>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) Carcinoma of the Quary</p> <p style="text-align: center;">DUE TO (b) Metastases to the</p> <p style="text-align: center;">DUE TO (c) Quarternal Caustic</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) 175.0</p> <p>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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____</p> <p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p> <p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>
<p>21. I attended the deceased from May 1963 to June 6, 1963 and last saw her alive on June 6, 1963</p> <p>Death occurred at 9:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE Lester J. Garrison (Degree or title) M.D.</p>	<p>22b. ADDRESS 2428 Woodson</p> <p>22c. DATE SIGNED 6/7/63</p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Removal</p>	<p>23b. DATE June 10, 1963</p> <p>23c. NAME OF CEMETERY OR CREMATORY St. Trinity Lutheran Cem.</p> <p>23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.</p>
<p>24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S. Kingshighway Blvd.</p>	<p>25. DATE RECD. BY LOCAL REG. JUN 7 1963</p> <p>26. REGISTRAR'S SIGNATURE Loan Smith, M.D.</p>

DO NOT WRITE ON THIS STUB

AMENDED

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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

Dr. Lester J. Zeffren

~~15 New Brantwood~~

~~Par. 56885~~

2428 Woodson Rd.

Ha. 7-2424

10.30.23

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 James R. Anna

Licensed Embalmer No. 4527

P.O. Address _____

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.