

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-022550

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1670

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JUN 11 1963**

VS 300  
Rev. 4/59

1 4002

2 4014

3

4 0

5 1

6

7 0

8 3

9974X

10

11

12 92.3

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in 1b <u>DOA</u>	c. CITY OR TOWN <u>St Ann</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Louis Co Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10234 Little Flower La</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>EMMENDORFER</u> Last			4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/1893</u>
9. AGE (last birthday) <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bus Operator</u>	11. BIRTHPLACE (City and state or country) <u>Perryville Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>John Emmendorfer</u>	
14. MOTHER'S MAIDEN NAME <u>Rose Miester</u>		15. NAME OF HUSBAND OR WIFE <u>Oma Emmendorfer</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW # 1 USN</u>		17. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Hanging</u>	
20c. TIME OF INJURY Hour <u>1:20</u> Month, Day, Year <u>5/22/63</u> <u>subject found</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>car-part (storage area)</u>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>St. Ann</u> COUNTY <u>St. Louis</u> STATE <u>Missouri</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>1:45 P.M.</u> p m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Raymond H. [Signature]</u> (Degree or title) Coroner		22b. ADDRESS <u>Clayton, Missouri</u>	
22c. DATE SIGNED <u>5/29/63</u>		22d. LOCATION (City, town, or county) (State) <u>Florissant Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/25/1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		23d. LOCATION (City, town, or county) (State) <u>Florissant Mo</u>	
24. FUNERAL DIRECTOR <u>Ortmann F Home</u> ADDRESS <u>9222 Lackland Overland Mo</u>		25. DATE RECD. BY LOCAL REG. <u>5-24-63</u>	
26. REGISTRAR'S SIGNATURE <u>John B. Murphy [Signature]</u>			

USE BLACK INK OR TYPEWRITER RIBBON

**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 Al C. Ostermann

Licensed Embalmer No. 3478

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.