

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-030429

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District **1003** Registrar's No. **7427**

STATE FILE NUMBER

FILED JUL 25 1963

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN d. STREET ADDRESS (If outside, give location)	
a. COUNTY b. CITY OR TOWN ST. LOUIS c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STONE NURSING		a. STATE Mo b. COUNTY c. CITY OR TOWN ST. LOUIS d. STREET ADDRESS (If outside, give location) 6039 OLEATHA	
3. NAME OF DECEASED (Type or print) First Middle Last CAROLINE REPOHL		4. DATE OF DEATH Month Day Year JULY 16 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH DEC 2 - 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (City and state or country) Mo.	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY U-S-A	
13a. FATHER'S NAME HENRY HOLLMANN		13b. MOTHER'S MAIDEN NAME CATHERINE WERNEX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT WALTER REPOHL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Arteriosclerosis. DUE TO (b) Arteriosclerosis, genl - DUE TO (c) 420.1		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) Arterio sclerotic Heart Disease		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 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.		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 1961 to 7-16-63 and last saw her/him alive on 6-25-63 Death occurred at 4 PM, 7-16-63 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE C. Homes, MD (Degree or title)		22b. ADDRESS 4401 Hampton Ave.	
22c. DATE SIGNED 7.17.63		22d. LOCATION (City, town, or county) (State) St. Louis Mo	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE JULY 19, 1963	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO
24. FUNERAL DIRECTOR Thomas Kuto		25. DATE RECD. BY LOCAL REG. JUL 18 1963	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

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

VS 300
Rev. 4/59

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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 Corley Henderson Jr.

Licensed Embalmer No. 4861

P. O. Address St. Louis 19, 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.

*Dr. Kerne 4401 Hammond St. 2-1-4808
Stone Nursing Home 231-2644
4373 N. Paul
2-630
MCA
The Am. S. H.*