

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-031002

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8562** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 29 1963

VS 300 Rev. 4/59
1
2 219
3
4 0
5 2
6
7 0
8 1
9
10
11
12 61-0
13

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

1. CITY OF DEATH
~~St. Louis~~ **City of St. Louis**

2. USUAL RESIDENCE (Where deceased lived... If institution: Residence before admission)
a. STATE **Mo.** b. COUNTY

3. CITY OR TOWN **St. Louis, Mo.** **Length of stay in 1b** **1 DAY**

4. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION **Firmin Desloge Hosp.** **Inside Limits** Yes No

5. DATE OF DEATH **August 22, 1963**

6. NAME OF DECEASED First **Fred** Middle **H** Last **Pettker**

7. SEX **Male** **8. COLOR OR RACE** **White** **9. AGE (last birthday)** **59**

10. MARRIAGE STATUS Married Never Married Widowed Divorced

11. DATE OF BIRTH **1-30-04** **12. CITIZEN OF WHAT COUNTRY** **U.S.A**

13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **TOWER OPERATOR** **14. KIND OF BUSINESS OR INDUSTRY** **AUTOMOTIVE** **15. BIRTHPLACE** (City and state or country) **ST LOUIS MO**

16. FATHER'S NAME **(Pettker, William)** **17. MOTHER'S MAIDEN NAME** **Unknown** **18. NAME OF HUSBAND OR WIFE** **MATE UHLAND LOUISE PETTKER**

19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) **YES** (If yes, give war or dates of service) **1922-1925** **20. SOCIAL SECURITY NO.** **21. INFORMANT** **FINNVALA BUODE 9179 WRENWOOD**

22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **CONGESTIVE HEART FAILURE**
DUE TO (b) **RHEUMATIC HEART DISEASE**
DUE TO (c) **416x**
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.
 Yes No Unknown

23. WAS AUTOPSY PERFORMED? YES NO **24. ACCIDENT SUICIDE HOMICIDE** **25. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in PART I or PART II of item 16.)

26. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

27. INJURY OCCURRED WHILE AT WORK **28. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **29. CITY, TOWN, OR LOCATION** **30. COUNTY** **31. STATE**

32. I attended the deceased from **August 1962** to **August 1963** and last saw him alive on **August 22, 1963**
Death occurred at **7 30** **pm** on the date stated above, and to the best of my knowledge, from the causes stated.

33. SIGNATURE (Degree or title) **B. Garrison Golden, M.D.** **34. ADDRESS** **1325 SO. GRAND** **35. DATE SIGNED** **8-23-63**

36. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** **37. DATE** **8/24/1963** **38. NAME OF CEMETERY OR CREMATORY** **CALHUNY CEM** **39. LOCATION** (City, town, or county) **ST. LOUIS MO** (State)

40. FUNERAL DIRECTOR **STOCK MORTUARY 889 S BRENTWOOD** **41. ADDRESS** **42. DATE RECD. BY LOCAL REG.** **AUG 23 1963** **43. REGISTRAR'S SIGNATURE** **Road Smith, M.D.**

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

Paul A. Wacker

Licensed Embalmer No.

4787

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.