

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041544

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9975

FILED OCT 17 1963

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

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Mo.</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis, Mo.</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 City Hosp #1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3622 Koeln Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Augusta</u> Middle <u>L.</u> Last <u>Heberer e</u>			4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>63</u>										
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4/10/1890</u>		9. AGE (last birthday) <u>73</u>		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) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Aug. Baker</u>				13b. MOTHER'S MAIDEN NAME <u>Louis Wittenbeche</u>				14. NAME OF HUSBAND OR WIFE <u>Frank Heberer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Irma Gaterman 4229 A Eichelberger</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Acute Peritonitis</u>										<u>24 hrs</u>			
DUE TO (b) <u>Perforated Duodenal Ulcer</u>										<u>24 hrs</u>			
DUE TO (c) <u>Chronic Duodenal Ulcer</u>										<u>2 Yrs (est)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>5411</u>										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 checked="" type="checkbox"/> NO <input 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 <u>4:25</u> a.m. p.m.		Month, Day, Year <u>10/3/63</u> to <u>10/6/63</u>		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 <u>10/6/63</u>		COUNTY <u>10/6/63</u>		STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>4:25 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>James M. Goggin M.D.</u>						22b. ADDRESS <u>1515 Lafayette Ave</u>		22c. DATE SIGNED <u>10/6/63</u>					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>10/9/1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Abbey</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>							
24. FUNERAL DIRECTOR <u>Witt Mortuary</u>				ADDRESS <u>6409 Gravois Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 8 1963</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>					

GOGGIN
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

Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.

With Embalming