

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12437 **63-049852**
STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB

VS 300
Rev. 4/59

1
2 **20**
3
4 **0**
5 **3**
6
7 **0**
8 **1**
9
10
11
12 **58-0**
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

| | | | | | |
|---|--|---|--|---|--|
| FILED DEC 20 1963 | | 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | a. STATE Mo. b. COUNTY St. Louis | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp. | | Length of stay in lb 2 days | | c. CITY OR TOWN St. Louis | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS 4831 Siegel | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | |
| First Middle Last Bernard Poehling | | | Month Day Year Dec. 15 1963 | | |
| 5. SEX Male | 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 6-25-1873 | 9. AGE (last birthday) 90 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Night Watchman | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis Mo. | |
| 13a. FATHER'S NAME August Poehling | | 13b. MOTHER'S MAIDEN NAME Bernadine Kunz | | 14. NAME OF HUSBAND OR WIFE Late Elizabeth Poehling | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No. None | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Elizabeth Poehling 4831 Siegel Ave. | |
| 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) Respiratory Failure | | | | | 3 days |
| DUE TO (b) Lobar pneumonia | | | | | |
| DUE TO (c) malnutrition | | | | | 2:86.5 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Congestive Failure | | | | | 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 checked="" type="checkbox"/> NO <input 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.) | | | |
| 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 Dec 5 1963 to Dec 14 '63 and last saw her alive on Dec 14, 1963 Death occurred at 1.50 A.m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Phillip Comens MD | | | 22b. ADDRESS 6500 Chippewa | | 22c. DATE SIGNED 12/16/63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 12-17-63 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo. | |
| 24. FUNERAL DIRECTOR ADDRESS Kriegshauser So. 4228 S. Kingshighway | | | 25. DATE RECD. BY LOCAL REG. DEC 18 1963 | | 26. REGISTRAR'S SIGNATURE Roald Amster M.D. |

Dr. Phillip Comens
6500 Chippewa FL2-8383

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 APW. Steward

Licensed Embalmer No. 4607

P. O. Address H. Lewis Dr

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.