

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045078
STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 1752

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 9 1963		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St. Charles		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		a. STATE Missouri b. COUNTY St. Charles	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 11 Eau Claire Dr.		Length of stay in lb Life		c. CITY OR TOWN St. Charles	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 11 Eau Claire Dr.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First MINNIE Middle S. Last QUADE			Month December Day 2 Year 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 7-30-1885	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY OWN		11. BIRTHPLACE (City and state or country) St. Charles, Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME John Bruns		13b. MOTHER'S MAIDEN NAME Fredricka Poncin	
14. NAME OF HUSBAND OR WIFE Julius C. Quade		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Carl Klinghammer Sr.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 YRS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		DUE TO (c) _____	
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 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.		Month, Day, Year _____			
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 <u>August 1955</u> to <u>December 1963</u> and last saw her alive on <u>June 20, 1963</u> Death occurred at <u>10:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Paul H. Rother MD</i>			22b. ADDRESS St. Charles, Mo		22c. DATE SIGNED 12/3/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-4-1963	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town, or county) St. Charles Missouri
24. FUNERAL DIRECTOR Arthur C. Baue			25. DATE RECD. BY LOCAL REG. Dec 3-1963		26. REGISTRAR'S SIGNATURE <i>Falmes Stewart</i>
ADDRESS 620 Jefferson St., St. Charles, Mo.			Mabel Zellwolt Dep		

VS 300
Rev. 4/59

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945.00

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Conrad Pickering

Licensed Embalmer No. 5189

P. O. Address St. Charles, 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.