

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0047124

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

DEFILED 14 64

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 53

STATE FILE NUMBER

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>STE. GENEVIEVE</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE. GENEVIEVE</u>			Length of stay in lb <u>76 YRS</u>		c. CITY OR TOWN <u>STE. GENEVIEVE</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>199 So 3rd.</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>199 So. 3rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>ROTH</u> Last <u>VORST</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>10</u> Year <u>1964</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>2/2/68</u>	9. AGE (last birthday) <u>96</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>AT HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>COFFMAN MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>CHARLES H. BIEL</u>			13b. MOTHER'S MAIDEN NAME <u>MARTHA FAULKNER</u>		14. NAME OF HUSBAND OR WIFE <u>JOSEPH H. VORST</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>Ann Thomas Ste. Genevieve Mo</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>Arteriosclerotic Heart disease.</u>						?	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						?	
DUE TO (b) <u>Chronic Myocarditis.</u>							
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 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.	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>Dec. 2, 1963</u> to <u>Dec. 10, 1964</u> and last saw her/him alive on <u>Dec. 10, 9</u> Death occurred at <u>6:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Al. Lanning M.D.</u> (Degree or title)			22b. ADDRESS <u>Ste. Genevieve Mo.</u>		22c. DATE SIGNED <u>12/11/64</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/13/64</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CRIST LAWN</u>		23d. LOCATION (City, town, or county) <u>STE. GENEVIEVE MO</u>		(State)	
24. FUNERAL DIRECTOR <u>Geo. C. Barber Ste. Genevieve Mo</u>			25. DATE RECD. BY LOCAL REG. <u>11 December 1964</u>		26. REGISTRAR'S SIGNATURE <u>George F. Wood</u>		

USE BLACK INK OR TYPEWRITER RIBBON

EXHIBIT 10

00 110 11 140

**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 *Alvin J. Ehlke*

Licensed Embalmer No. 4740

P. O. Address St. Bernard 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.