

STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 26 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1645**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1645	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE _____ b. COUNTY _____ NO. _____			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis.		d. STREET ADDRESS 5800 Arsenal St.		e. CITY OR TOWN 2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary				d. STREET ADDRESS (If rural, give location) 13			
3. NAME OF DECEASED (Type or Print) Sophie		a. (First)		b. (Middle)		c. (Last) Behnke	
4. DATE OF DEATH (Month) (Day) (Year) February 11, 1953		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH MAR 5 1868		9. AGE (In years last birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		11. BIRTHPLACE (City and State or Foreign Country) Germany Europe 4	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Henry Behnke		13b. MOTHER'S MAIDEN NAME Annie - PULS		14. NAME OF HUSBAND OR WIFE NONE	
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'S SIGNATURE OR NAME City Infirmary Records-5800 Arsenal St.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200					
22. I hereby certify that I attended the deceased from MAY 29, 19 45 , to February, 11, 53 , that I last saw the deceased alive on Feb. 11, 19 53 , and that death occurred at 5:25Am. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Valerie Druaine Rowlich M.D.				23b. ADDRESS 5800 Arsenal St.		23c. DATE SIGNED 2-11-53.	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE FEB 13 1953		24c. NAME OF CEMETERY OR CREMATORY OLD PICKER CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL REG. FEB 11 1953		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Bravo			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed

Samuel C. Dill

Licensed Embalmer No. *43477*

P. O. Address *2906 Hawaii*

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 this body is not embalmed, fact should be so stated above.