

FILED SEP 22 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31177

State File No.

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri		b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Fulton		c. CITY OR TOWN Pine Lawn		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (In this place) 10 yrs		e. STREET ADDRESS (If rural, give location) 4001			
3. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital		4. DATE OF DEATH (Month) (Day) (Year) Sept 4 1953			
NAME OF DECEASED a. (First) Elizabeth		b. (Middle) Rindfleish		c. (Last) Rindfleish	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	
8. DATE OF BIRTH July 6 1878		9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months 1 Days 28	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME deceased		14. MOTHER'S MAIDEN NAME DK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME State Hospital Records, Fulton, Mo.	
18. ADDRESS State Hospital Records, Fulton, Mo.		MEDICAL CERTIFICATION			
CAUSE OF DEATH or only one cause per for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
This does not mean mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES DUE TO (b) Myocarditis DUE TO (c) Cerebral Embolism			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)	
TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
I hereby certify that I attended the deceased from July 1 , 19 53 , to Sept 4 , 19 53 , that I last saw the deceased alive on Sept 3 , 19 53 , and that death occurred at 3:20 A m., from the causes and on the date stated above.					
SIGNATURE M. D.		23b. ADDRESS State Hospital, Fulton, Mo		23c. DATE SIGNED 9/4/53	
BURIAL, CREMATION, REMOVAL (Specify)		24c. NAME OF CEMETERY OR CREMATORY State Hospital		24d. LOCATION (City, town, or county) (State) State Hospital Grounds	
DATE 9-15-53		25. FUNERAL DIRECTOR'S SIGNATURE G. E. Thomas		ADDRESS 302 Market St. Fulton, Mo	
RECD BY LOCAL REG. pt. 15-1953		REGISTRAR'S SIGNATURE Maretta Lawrence		426-0	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate
by me, or by, Student Embalmer N
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer N

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING
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.