

XC 2 758 434
SL 12889

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
15196
3718

FILED MAY 6 - 1957

318

1003

Registration District No. Primary-Registration District No. Registrar's No.

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Gasconade		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. Grand St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN MORRISON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V. A. HOSPITAL		Length of stay in 1b 53 Days	STREET ADDRESS NONE		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle G. Last RINNE			4. DATE OF DEATH Month Day Year 4/17/57		
5. SEX MALE <input checked="" type="checkbox"/>	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 12/29/86	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (City and state or country) Morrison, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Rinne			14. MOTHER'S MAIDEN NAME Minnie Karmner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address VA HOSPITAL RECORDS ST. LOUIS, MO.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: . . . IMMEDIATE CAUSE (a) Calcific aortic stenosis					INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) Arteriosclerosis Unk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a. m. p. m.		421.1			
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. VA Attended the deceased from 2/23/57 to 4/17/57 and last saw him alive on 4/17/57 Death occurred at 2:20 Pm on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Albert H. Hoppe			22b. ADDRESS M.D. VAH, ST. LOUIS 6 MISSOURI		22c. DATE SIGNED 4/17/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-17-57	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Hermann Mo	
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington		ADDRESS		25. DATE RECD. BY LOCAL REG. APR 18 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. M.S.B.

DATE: 10/10/50

abstract

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 *Stanley H. D...*
.....

Licensed Embalmer No. 4419

P. O. Address *St. Louis*

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.