

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38616

STATE FILE NUMBER

FILED NOV 15 1957

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2604

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Clayton</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>St. Marys Hospital</u>		Length of stay in 1b <u>5wks</u>	d. STREET ADDRESS (If outside, give location) <u>7520 Oxford Dr.,</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ann Elizabeth Rhotemael</u>			4. DATE OF DEATH Month Day Year <u>Oct. 19, 1957</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>Nov. 23, 1859</u>	9. AGE (In years last birthday) <u>97yrs</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>John Rex</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Hooper</u>		14. NAME OF HUSBAND OR WIFE <u>James H. Rhotemael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <u>None</u>) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs. Amelia Burton Maxwell 7520 Oxford</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>9/11/57</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension - cerebral arteriosclerosis, generalized arterio-sclerosis</u>					Interval between onset and death <u>Several years.</u>
DUE TO (c) <u>End arteries obliterans left leg</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>End arteries obliterans left leg</u>					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.) <u>331X</u>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1111 11th</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Louis Mo</u>	
21. I attended the deceased from <u>9/11/57</u> to <u>10/19/57</u> and last saw her alive on <u>10/19/57</u> Death occurred at <u>1 P.M. - 10/19/57</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Thomas C. Anderson M.D.</u>			22b. ADDRESS <u>4660 Maryland St -</u>		22c. DATE SIGNED <u>10/21/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Oct. 22, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>
24. FUNERAL DIRECTOR <u>W. J. Anderson & Sons 6175 Delmar</u>			25. DATE RECD. BY LOCAL REG. <u>10-22-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Romberg</u>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr Thomas Birdall
4660 Maryland
Fo 1-6074

MS
DEC 30 1958

JAN 8 0 1958

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 *jos. e. McCulloch*

Licensed Embalmer No. *2460*

P. O. Address *6775 Delma*

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.