Health, Welfare Public Service

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FILED MAY 7 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-016718
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 920

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSP. — Length of stay in 1b D.O.A

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Clayton 4000 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 8401 LOUWEN DR. (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Bobye Middle: S. Last: Rindskopf

4. DATE OF DEATH Month 3 Day 29 Year ~~59~~ 58

5. SEX Female
6. COLOR OR RACE W.
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 1/3/1894
9. AGE (In years last birthday) 64 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
10b. KIND OF BUSINESS OR INDUSTRY housewife
11. BIRTHPLACE (City and state or country) Memphis Tenn.
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Jessie Schloss
13b. MOTHER'S MAIDEN NAME Rachael Parks
14. NAME OF HUSBAND OR WIFE Wallace Rindskopf
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 WALLACE RINDSKOPF Address 8401 LOUWEN DR

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 5 years.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) 4201
DUE TO (c) Had two previous Coronary occlusions
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

corrected by affidavit 5/7/58

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 Feb 1950, to March 1958 and last saw her/him alive on March 29 1958
Death occurred at 6:20 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Howard Freedman (Degree or title) MD
22b. ADDRESS 607 No. Grand Blvd
22c. DATE SIGNED 3/30/58

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 3/31/58
23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai
23d. LOCATION (City, town, or county) St. Louis Co (State) Mo.

24. FUNERAL DIRECTOR Mayer ADDRESS 4356 Lindell.
25. DATE RECD. BY LOCAL REG. 4-1-58
26. REGISTRAR'S SIGNATURE Herbert F. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Elmer R. Sadwell

Licensed Embalmer No. 4077

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.