

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034698

FILED OCT 13 1959 317

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2670

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>								
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in 1b		c. CITY OR TOWN <b>Richmond Heights</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6420 Clayton Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Aloysia Ripperger</b>				4. DATE OF DEATH Month Day Year <b>October 6, 1959</b>								
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-26-1894</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NUN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGION</b>		11. BIRTHPLACE (City and state or country) <b>Bauer, Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Alois Ripperger</b>			13b. MOTHER'S MAIDEN NAME <b>Barbara A. Bauer</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Sister M. Francine, 1100 Bellevue Avenue</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>							INTERVAL BETWEEN ONSET AND DEATH <b>9-25-59</b>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) <b>Pulmonary infarction, left base</b>		<b>9-25-59</b>			
							DUE TO (c) <b>Coronary occlusion with myocardial infarction</b>		<b>9-25-59</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. Month, Day, Year												
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. I attended the deceased from <b>9-25-59</b> to <b>10-6-59</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>10-6-59</b> Death occurred at <b>5:05 p.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.												
22. SIGNATURE (Type or print) <b>James P. Wade MD</b>					22b. ADDRESS <b>634 N. Grand</b>				22c. DATE SIGNED <b>10-7-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT 9, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION</b>			23d. LOCATION (City, town, or county) (State) <b>ST LOUIS COUNTY</b>					
24. FUNERAL DIRECTOR <b>J. H. Potholke</b>			ADDRESS <b>6536 Clayton Rd</b>			25. DATE RECD. BY LOCAL REG. <b>10-8-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>				

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Chas R Caldwell

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.