

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041495

FILED VS NOV 20 1959

210447

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 mo.	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4341 Westminster Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Rosa Middle Anna Last Albright			4. DATE OF DEATH Month 11 Day 12 Year 59		
5. SEX Female	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 12-19-1877	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months 10 Days 22 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Pomeroy, Ohio	11. BIRTHPLACE (City and state or country) Ohio	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Conrad Joachin		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Wm. Albright	
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 Wm. Mansfield 8 Long Meadows		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Basilar Congesting Heart					INTERVAL BETWEEN ONSET AND DEATH 3 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Anterior Myocardial Infarct					3 mo.
DUE TO (c) Arteriosclerotic Heart Disease					3 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis - 3 mo.				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) 420.0			
20c. TIME OF INJURY Hour _____ a.m. _____ p.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 8-5-59 to 11-12-59 and last saw her/him alive on 11-12-59		Death occurred at 5:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John W. Beckham, M.D.		22b. ADDRESS 5800 Arsenal		22c. DATE SIGNED 11/13/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-13-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR A. H. Bocklage		ADDRESS 6536 Clayton Rd.	25. DATE RECD. BY LOCAL REG. NOV 13 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Not Embalmed
A. H. Bocke

Licensed Embalmer No. _____

P. O. Address _____

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.