

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003203

FILED VS FEB 10 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 1140** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS,</b>		Length of stay in 1b <b>LIFE</b>		c. CITY OR TOWN <b>ST LOUIS,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST JOHN'S HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>8669 PARTRIDGE AVE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle Last <b>BURKE</b>				4. DATE OF DEATH Month <b>JAN,</b> Day <b>30,</b> Year <b>1960</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5/29/1885</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ST LOUIS MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>GEORGE AHRENS</b>			13b. MOTHER'S MAIDEN NAME <b>ANNA CHIFFIE</b>			14. NAME OF HUSBAND OR WIFE		
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>CHRIS BURKE 4860 CARTER AVE</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 Thrombosis</b> DUE TO (b) <b>Arterio sclerosis</b> DUE TO (c) <b>4201</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>4-5 Days</b> <b>6 yrs +</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 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.)						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>1953</b> to <b>1/30/60</b> and last saw her <del>him</del> alive on <b>1/30/60</b> Death occurred at <b>11:00 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Robert J. Sausville MD</b>				22b. ADDRESS <b>8521 N. B'dway</b>		22c. DATE SIGNED <b>2/1/60</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>2/2/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		23d. LOCATION (City, town, or county) <b>ST LOUIS MISSOURI</b>		23e. (State)		
24. FUNERAL DIRECTOR ADDRESS <b>STROOT - CARROLL 4600 NATURAL BRIDGE</b>			25. DATE RECD. BY LOCAL REG. <b>FEB 1 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <b>MOB</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*2000  
8321 No. B...  
2-1-1060*

**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 W W Ruetter

Licensed Embalmer No. 4865

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.