

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS FEB 11 1960

-60-003702

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **1094** STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE MO.	b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DESLOGE HOSP.		d. STREET ADDRESS (If outside, give location) 3914 FOLSOM	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First	Middle	Last	Month	Day	Year	
Hulda	ANN	Lee	1	-29-	60	

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-29-1879	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
--------------------------------	---	---	---	--	--	-------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) BENTON, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	--	---	---

13a. FATHER'S NAME JOHN KIFER	13b. MOTHER'S MAIDEN NAME MARY HESS	14. NAME OF HUSBAND OR WIFE BEN LEE
--	--	--

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 CLIFFORD LANCASTER	Address 3223 PARK AV.
--	---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) acute asthmatic syndrome		
DUE TO (b) chronic obstructive emphysema		
DUE TO (c) 527.1		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)	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 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 **1-28-60** **to** **1-29-60** **and last saw her** **alive on** **1-28-60**
Death occurred at **12:05 am** **m** **on the date stated above, and to the best of my knowledge, from the causes stated.**

22a. SIGNATURE (Degree or title) Robert R. Pierre M.D.	22b. ADDRESS 1325 S. Grand.	22c. DATE SIGNED 1-29-60
---	--	---

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE FEB. 1, 1960	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	23d. LOCATION (City, town, or county) (State) ST. LOUIS CO., MO
--	---	---	--

24. FUNERAL DIRECTOR KRIEBSHAUSER 4228 S. KINGS HIGHWAY	25. DATE RECD. BY LOCAL REG. JAN 30 1960	26. REGISTRAR'S SIGNATURE Loan 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 R. W. Stovesand

Licensed Embalmer No. 4007

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.