

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

-60-003902

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2** **808** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Webster Groves	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If outside, give location) 136 Dornell	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERTA F. PATE		4. DATE OF DEATH Month Day Year Jan. 21 1960	
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 12/9/ 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Cincinnati Ohio	9. AGE (last birthday) 85
13a. FATHER'S NAME Robert Fraser		13b. MOTHER'S MAIDEN NAME Martha Protzman	12. CITIZEN OF WHAT COUNTRY U. S. A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. No	17. INFORMANT Wm. Pate Address Webster Groves
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Thrombosis Abdominal Aorta and Lower Mesenteric Arteries. DUE TO (b) Chronic Severe Enteritis DUE TO (c) 454x			INTERVAL BETWEEN ONSET AND DEATH 2 days + 3 weeks +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal Bilateral Pneumonia. Bronchiectasis. Incontin. - 4 mos.			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 checked="" type="checkbox"/> NO <input 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 October 9, 1946 to January 21, 1960 last saw her alive on January 21, 1960 Death occurred at 5 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS M.O. 804 Hamilton Blvd. St. Louis 12 Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22c. DATE SIGNED 1-22-60	
23b. DATE Jan 25 1960		23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	
24. FUNERAL DIRECTOR C.R. Lupton and Sons 7233 Delmar		23d. LOCATION (City, town, or county) (State) St. Louis Mo.	
25. DATE RECD. BY LOCAL REG. JAN 23 1960		25. REGISTRAR'S SIGNATURE <i>[Signature]</i> S.P.	

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 Clarence H. Miller

Licensed Embalmer No. 4011

P. O. Address St. Louis

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.