

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004646

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Registration District No. 317 Primary Registration District No. 500 Registrar's No. 175 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Perry</b>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Des Peres</b>		Length of stay in 1b <b>2 months</b>	c. CITY OR TOWN <b>Perryville</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>908 Des Peres Dr.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>Route 2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Unterreiner</b> Last <b>Unterreiner</b>			4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>1960</b>			
5. SEX <b>Male</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>5/25/1878</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Apple Creek, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		
13a. FATHER'S NAME <b>Paul Unterreiner</b>		13b. MOTHER'S MAIDEN NAME <b>Cecelia Weber</b>		14. NAME OF HUSBAND OR WIFE <b>Wilhelmina</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>Edward F. Thomas, 908 Des Peres Dr.</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>Cerebral Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Chronic Cardio Vascular Renal Dis</b>			<b>Chronic</b>	
		DUE TO (c) <b>Diffuse Arterio Sclerosis Advanced</b>			<b>Chronic</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senility</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.						
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>Mar 10-59</b> to <b>Jan 16-60</b> and last saw her/him alive on <b>Jan 15-60</b> . Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Harold C. [Signature]</b>		(Degree or title)	22b. ADDRESS <b>2816 Sutton St. Louis 17 Mo</b>		22c. DATE SIGNED <b>1/15/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-20-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Apple Creek, Mo.</b>			
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>1-18-60</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(OFFICIAL USE ONLY)

Faded header text, likely containing fields for name, address, and other identifying information.

**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 Robert M. Murra

Licensed Embalmer No. 3749  
P. O. Address St Louis

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