RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS FEB 25 1960

-60-008099

2 1090

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.
Length of stay in 1b: [illegible]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Luke's Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN: Richmond Heights, Mo.
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1027 Claytonia Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First MARIE Middle LOUISE Last DANFORTH

4. DATE OF DEATH: Month Jan. Day 29, Year 1960.

5. SEX: F
6. COLOR OR RACE: W.
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: July 26, 1897
9. AGE (last birthday): 62
IF UNDER 1 YEAR: Months 6 Days 3 Hours Min.
IF UNDER 24 HR: 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:
11. BIRTHPLACE (City and state or country): Louisville, Ky.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: James Alley
13b. MOTHER'S MAIDEN NAME: M. Johnson
14. NAME OF HUSBAND OR WIFE: Francis Danforth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Dorothy Bahn Address: 1106 Edwards Terrace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Cardio-vascular Dis. — 10 years
DUE TO (c) 443X

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1950 to Jan. 29, 1960 and last saw her/him alive on Jan. 29, 1960
Death occurred at 8 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): George H. Luer M.D.
22b. ADDRESS: 600 N. Union
22c. DATE SIGNED: 1-30-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb. 1, 1960.
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: A.H. Bocklage F.H.
ADDRESS: 6536 Clayton Rd.
25. DATE RECD. BY LOCAL REG.: JAN 30 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed Harvey Kahle

Signature of Student Embalmer

Licensed Embalmer No. 4596

P. O. Address St Louis

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