URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS FEB 23 1960

60-008114

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1581

ENDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST.LOUIS,MO — Length of stay in 1b

c. CITY OR TOWN ST. LOUIS,MO — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST.LOUIS CITY HOSP. #1. — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 2517 N. 22nd — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First GERTRUDE Middle DEMSEY Last

4. DATE OF DEATH Month JAN. Day 8, Year 1960

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. Married ☐ Never Married ☐ Widowed ☐ ?? Divorced ☐ UNKNOWN

8. DATE OF BIRTH 12/17/87

9. AGE (last birthday) 72 — 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) UNKNOWN

10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN

11. BIRTHPLACE (City and state or country) UNKNOWN

12. CITIZEN OF WHAT COUNTRY UNKNOWN

13a. FATHER'S NAME PIERIE FRANCIOS

13b. MOTHER'S MAIDEN NAME NOTI KNOWN

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. none

17. INFORMANT Address ST.LOUIS CITY HOSP. #1.

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) Congestive heart failure

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c) 420.0

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 1/6/60, to 1/8/60 and last saw her/him alive on 1/8/60

Death occurred at 7:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Bert J. Stein MD

22b. ADDRESS 1515 LAFAYETTE AVE

22c. DATE SIGNED 1/8/60

23a. BURIAL, CREMATION, REMOVAL (specify)

23b. DATE 2-29-60

23c. NAME OF CEMETERY OR CREMATORY Anatomical Board

23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR Rowland Mortuary Svc. ADDRESS 4104-06 Manchester

25. DATE RECD. BY LOCAL REG. FEB 11 1960

26. REGISTRAR'S SIGNATURE Carl Smith. M.D. MDB

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.