URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-008236

STATE FILE NUMBER

FILED VS MAR 8 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1994

NDED

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 2 DAYS

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

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

d. STREET ADDRESS (If outside, give location) 5069 A WINONA — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First STELLA Middle — Last GAREY

4. DATE OF DEATH Month 2 Day 19 Year 1960

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐

8. DATE OF BIRTH 1-30-1872

9. AGE (last birthday) 88 — 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) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY NONE

11. BIRTHPLACE (City and state or country) DRAMENN, NORWAY

12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME HANS JACOBSON

13b. MOTHER'S MAIDEN NAME OLIVE GUTHORMSEN

14. NAME OF HUSBAND OR WIFE JOHN GAREY

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 Address MRS. LUCILLE HARPER 5069 A WINONA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Fracture of Left Hip

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

DUE TO (b) Bronchial Pneumonia

DUE TO (c) 904.0

INTERVAL BETWEEN ONSET AND DEATH

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.) Suffered when deceased fell in Home on February 17th 1960

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 21760

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.) 14 Home

20f. CITY, TOWN, OR LOCATION St Louis COUNTY Mo STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 530 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul J Simon (Degree or title) Deputy Coroner

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 2/20/60

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION

23b. DATE 2-22-1960

23c. NAME OF CEMETERY OR CREMATORY MISSOURI CREMATORY

23d. LOCATION (City, town, or county) ST. LOUIS, MO (State)

24. FUNERAL DIRECTOR HOWARD H. MICHEL ADDRESS 5930 SOUTHWEST

25. DATE RECD. BY LOCAL REG. FEB 20 1960

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4329

P. O. Address _____

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