URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-008481

FILED VS MAR 7 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1981 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. John's Hosp.

Inside Limits: Yes ☐ No ☐

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

c. CITY OR TOWN: St. Louis

Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 3871 Utah Pl.

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: CECELIA Middle: E. Last: KRINGS

4. DATE OF DEATH: Month: Feb. Day: 18 Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 2-22-1874

9. AGE (last birthday): 85

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): Housework

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (City and state or country): St. Louis, Mo.

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

13a. FATHER'S NAME: Francis Krings

13b. MOTHER'S MAIDEN NAME: Marie Schuettner

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: Anna M. Kuntz Address: 3871 Utah Pl.

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): Carcinoma, ovarian — INTERVAL BETWEEN ONSET AND DEATH: Unknown

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

DUE TO (b): _____

DUE TO (c): 175.0

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 11/6/60, to 2/18/60 and last saw her/~~him~~ alive on 2/18/60

Death occurred at 9:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] M.D. (Degree or title)

22b. ADDRESS: 634 No. Grand

22c. DATE SIGNED: 2/19/60

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

23b. DATE: Feb. 22, 1960

23c. NAME OF CEMETERY OR CREMATORY: S/S Peter & Paul Cem.

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

24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG.: FEB 19 1960

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

(Licensed Embalmer's Statement on Reverse Side)

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

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. 4533

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.