

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008529

FILED VS. MAR 14 1960

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>Glasgow Hills</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>10348 DURNESS</u>	
3. NAME OF DECEASED (Type or print) <u>Augusta</u> First <u>Locker</u> Middle Last			4. DATE OF DEATH <u>Feb. 25 1960</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1873</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>		13a. FATHER'S NAME <u>August Wendt</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Bauer</u>	
14. NAME OF HUSBAND OR WIFE <u>Late Samuel Locker</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Gladys Victor, 18 Northridge Hills Ct.,</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Fibrosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>525x</u> <u>SEV. YEARS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease, Arteriolar Nephrosclerosis</u>					PART III. If deceased was female was there a pregnancy, in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year		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 <u>Feb. 16, 1960</u> to <u>Feb. 25, 1960</u> and last saw her/him alive on <u>Feb. 24, 1960</u> Death occurred at <u>1:00A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Paul J. Bethonville M.D.</u> (Degree or title)		22b. ADDRESS <u>2415 N. Kingshighway</u>		22c. DATE SIGNED <u>2/26/60</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>2-27-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 26 1960.</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>	
24. FUNERAL DIRECTOR <u>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd. FUNERAL HOME, St. Louis, 15, Missouri.</u> ADDRESS					

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE BOARD OF HEALTH

**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 Ralph C. Leudin

Licensed Embalmer No. 4275

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.