

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008573

FILED VS. MAR 11 1960

2 2589

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |  | Length of stay in 1b  | c. CITY OR TOWN <b>St. Louis</b>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>Homer G. Phillips</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>5971a Theodosia</b>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Alice</b> Middle <b>McMenigle</b> Last <b>McMenigle</b>   |  |   | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>3</b> Year <b>60</b>  |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-20-1894</b>  | 9. AGE (last birthday)<br><b>66</b>   | IF UNDER 1 YEAR<br>Months _____ Days _____                                 |
| IF UNDER 24 HR<br>Hours _____ Min. _____  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>house work</b> |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Missouri</b>   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                               |
| 13a. FATHER'S NAME<br><b>Anton Bartozeski</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Elizabeth Yager</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Deceased</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT Address<br><b>Mrs. Roy Ramseyer 5971a Theodosia</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Transitional Cell Carcinoma of Bladder</b>   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Undet.</b>                          |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <b>181.0</b>   |  |   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Arteriosclerotic Heart Disease, ..</b>  |  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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<br>Month, Day, Year _____<br>Hour _____ a.m. _____ p.m.   |  |   |   |   |  |
| 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 <b>2-14-60</b> to <b>3-3-60</b> and last saw her <b>OK</b> alive on <b>3-3-60</b><br>Death occurred at <b>8:45</b> a. m on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Maie B. Hariford M.S.</b>  |  |   | 22b. ADDRESS<br><b>2601 N. Whittier St.</b>   |   | 22c. DATE SIGNED<br><b>3-4-60</b>  |
| 23a. BURIAL, CREATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>3-7-1960</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>   | 23d. LOCATION (City, town, or county)<br><b>St. Louis</b>   | 23e. (State)<br><b>Missouri</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Jos. W. Clark F.H. 1125 Hodiamont</b>  |  | ADDRESS   | 25. DATE RECD. BY LOCAL REG.<br><b>MAR 5 1960</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Karl Smith, M.D.</b>  |  |

DOCUMENT

MEDICAL CERTIFICATION

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Alfred J. Boer  
Licensed Embalmer No. 26

P. O. Address 11257 H

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