

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008592

FILED VS FEB 25 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 1832** STATE FILE NUMBER

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| 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 | | Length of stay in 1b 4 yrs. 3 | c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 4513 S. Kingshighway Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Anna Middle W. Last Maune | 4. DATE OF DEATH Month 2 Day 13 Year 60 |
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| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3-31-68 | 9. AGE (last birthday) 91 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|-------------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Mo. | 12. CITIZEN OF WHAT COUNTRY U.S. |
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| 13a. FATHER'S NAME Frederich Maune | 13b. MOTHER'S MAIDEN NAME Catherine Gronoled | 14. NAME OF HUSBAND OR WIFE None |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address St. Louis Chronic Hospital Records |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Middle Cerebral Art. Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 6 mo. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Hypertensive Cardiovascular Disease | 4 yrs. |
| | DUE TO (c) Generalized Arteriosclerosis | 4 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 443x | | 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 |

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| 19. WAS AUTOPSY PERFORMED? 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.) |
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| 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 |
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| 21. I attended the deceased from 11-9-55 to 2-13-60 and last saw her/him alive on 2-13-60 Death occurred at 6:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) John W. Beckham, M.D. | 22b. ADDRESS 5800 Arsenal | 22c. DATE SIGNED 2/15/60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 2/17/60 | 23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri. |
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| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd. | 25. DATE RECD. BY LOCAL REG FEB 17 1960 | 26. REGISTRAR'S SIGNATURE Carl Smith, M.D. |
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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 Ray W Wilkins

Licensed Embalmer No. 357

P. O. Address St Louis

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