

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. MAR 8 1960

STATE FILE NUMBER  
**60-009053**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 2296**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b <i>2 mo.</i>	c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. # 1</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <i>4317<sup>th</sup> De Fontey</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Isabell</b> First Middle Last <b>Welp</b>			4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1960</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>4/24/1893</i>	9. AGE (last birthday) <i>66</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Ill.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13a. FATHER'S NAME <i>George Faulkner</i>		13b. MOTHER'S MAIDEN NAME <i>Hanna Hecker</i>		14. NAME OF HUSBAND OR WIFE <i>John</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. —		17. INFORMANT <i>Mrs. V. Kissel 4317<sup>th</sup> De Fontey</i> Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Basilar Artery Thrombosis</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>332x</i>	
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)	
20c. TIME OF INJURY Hour Month, Day, Year 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>12-19-59</b> to <b>2-25-60</b> and last saw her/him alive on <b>2-25-60</b> Death occurred at <b>6:50</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>Robert K. Lane M.D.</i> (Degree or title)		22b. ADDRESS <i>1515 Lafayette Ave.</i>		22c. DATE SIGNED <b>2-25-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>2/29/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New St. Marcus</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County Mo.</i>	
24. FUNERAL DIRECTOR <i>Geo. A. Howard 1619 S. Grand</i> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>FEB 27 1960</b>	26. REGISTRAR'S SIGNATURE <i>Robert Smith M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*B.P.*

**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 Clarence M. Billo

Licensed Embalmer No. 437

P. O. Address ST Louis 9

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.