

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012526

FILED VS MAR 25 1960

Registration District No. _____ Primary Registration District No. _____ Registrar **3 3016** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS,		c. CITY OR TOWN ST LOUIS,	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DE PAUL HOSPITAL		d. STREET ADDRESS (If outside, give location) 5150 ASHLAND AVE	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First RALPH Middle BRYANT Last DRURY			4. DATE OF DEATH MARCH 12, 1960 Month Day Year		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/23/1891	9. AGE (last birthday) 68	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) RETIRED PRINTER	10b. KIND OF BUSINESS OR INDUSTRY ORCHARD PAPER CO.	11. BIRTHPLACE (City and state or country) WATERLOO ILLINOIS	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME DRURY	13b. MOTHER'S MAIDEN NAME KATHERINE	14. NAME OF HUSBAND OR WIFE ELSIE DRURY
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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) YES WORLD WAR I,	16. SOCIAL SECURITY NO. # 494-10-9308	17. INFORMANT ELSIE DRURY 5150 ASHLAND AVE Address
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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) Congestive cardiac failure		INTERVAL BETWEEN ONSET AND DEATH 48 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertens H. D.	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Metastatic spread to ribs from bronchial ca	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
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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 **1958** to **3-12-60** and last saw ^{her}him alive on **3-12-60**
Death occurred at **3 p** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W.D. Carroll M.D.	22b. ADDRESS De Paul Hospital	22c. DATE SIGNED MAR 15 1960
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 3/16/60	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS MISSOURI
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24. FUNERAL DIRECTOR STROOT - CARROLL 4600 NATURAL BRIDGE AVE ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 15 1960	26. REGISTRAR'S SIGNATURE Roald Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Dr Cassin
not to be used
4972
30 78844 1/2m*

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 M W Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis M

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.