

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS APR 12 1960

60-013037

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3348** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ST. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Missouri		Length of stay in 1b 35 hours	c. CITY OR TOWN Maplewood		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Evangelical Deaconess Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2824 Laclede St. Rd.	
3. NAME OF DECEASED (Type or print) First Della Middle Marie Last Oetting			4. DATE OF DEATH Month 3 - Day 12 Year 60		
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 3-11-60	9. AGE (last birthday)	IF UNDER 1 YEAR Months 1 Days 11 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Alexander Charles Oetting		13b. MOTHER'S MAIDEN NAME Mildred Gladys Phillips		14. NAME OF HUSBAND OR WIFE -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> or unknown)		16. SOCIAL SECURITY NO. -	17. INFORMANT Alexander Charles Oetting Address 2824 Laclede Station, Maplewood 17, Miss. Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease -		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Anencephalic monster	
	DUE TO (c) 750x	

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 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.)	
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 **3-11-60** to **3-12-60** and last saw her/him alive on **3-12-60**
 Death occurred at **10 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Lee A. Hall, M.D.	22b. ADDRESS 35 N. Central Ave	22c. DATE SIGNED 15 Mar 60
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE MAR 31 1960	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR Rowland Mortuary Svc. 4104-06 Manchester	25. DATE RECD. BY LOCAL REG. MAR 24 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. ms
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.