

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-013111**

**FILED VS MAR 17 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 2695** STATE FILE NUMBER

|   |   |   |   |  |   |  |   |       |
|---|---|---|---|--|---|--|---|-------|
| 1. PLACE OF DEATH<br>a. COUNTY  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Indiana</b> b. COUNTY <b>Vigo</b> |   |  |   |       |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MISSOURI</b>   |   | Length of stay in 1b  |   | c. CITY OR TOWN <b>Terre Haute</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |       |
| c. FULL NAME OF (If NOT in hospital, give name of HOSPITAL OR INSTITUTION) <b>BARNES HOSPITAL</b>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                    |  | d. STREET ADDRESS (If outside, give location)<br><b>1221 South 6th Street.,</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FREDERICK</b> Middle <b>CARL</b> Last <b>RECKERT</b>  |   |   |   | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>6</b> Year <b>1960</b>   |   |  |   |       |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>12/27/1887</b>  | 9. AGE (last birthday)<br><b>72</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>Retired Executive</b>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-Employed</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>Terre Haute, Indiana</b>       |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |       |
| 13a. FATHER'S NAME<br><b>Frederick C. Reckert Sr.</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Matilda Ehrmann</b>   |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Aileen Reckert</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>Nil</b>   |   | 17. INFORMANT<br><b>Unknown</b>  |   | Address<br><b>Aileen Reckert, 1221 So. 6th Street.,</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>MYOCARDIAL INFARCTION</b>                    |   |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>FEW DAYS</b>                                   |       |
| DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>   |   |   |   |  |   |  | YEARS   |       |
| DUE TO (c) _____  |   |   |   |  |   |  |   |       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>SEVERE GENERALIZED ARTERIOSCLEROSIS</b> |   |   |   |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |       |
| 19. WAS AUTOPSY PERFORMED?<br>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.)  |   |  |   |  |   |       |
| 20c. TIME OF INJURY<br>Hour _____<br>a.m. _____<br>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 <b>FEB. 8, 1954</b> to <b>MARCH 6, 1960</b> and last saw <sup>her</sup> him alive on <b>MARCH 6, 1960</b>                                      |   |   |   | Death occurred at <b>3:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.                  |   |  |   |       |
| 22a. SIGNATURE (Degree or title)<br><i>C. P. Smillion, M.D.</i>   |   |   |   | 22b. ADDRESS<br><b>BARNES HOSPITAL</b>   |   |  | 22c. DATE SIGNED<br><b>3/7/60</b>   |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |   | 23b. DATE<br><b>3/10/60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Park Crematorium<br/>Flanner-Buchanan Crematory</b> |  | 23d. LOCATION (City, town, or county)<br><b>Indianapolis, Indiana.</b>          |  |   |       |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe, Inc., 4700 Washington Blvd.,</b>  |   | ADDRESS   |   | 25. DATE RECD. BY LOCAL REG.<br><b>MAR 8 1960</b>  |   | 26. REGISTRAR'S SIGNATURE<br><i>C. P.</i>  |   |       |

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Funeral Director MEDICAL CERTIFICATION DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed [Handwritten Signature]

Licensed Embalmer No. 3111

P. O. Address [Handwritten Address]

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