

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013562

FILED **YS MAR 30 1960**

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 559 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>	Length of stay in 1b <u>1 hr.</u>	c. CITY OR TOWN <u>University City</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>County Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7553 Cornell</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ADELE</u> Middle <u>PARKER</u> Last			4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 22</u>	9. AGE (last birthday) <u>37</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Boston, Mass.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Jacob Heller</u>		13b. MOTHER'S MAIDEN NAME <u>Annie</u>		14. NAME OF HUSBAND OR WIFE <u>Arthur</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>U nk.</u>	17. INFORMANT <u>Arthur Parker 7553 Cornell</u>	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) <u>Unknown natural cause</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

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	
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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.) <u>Unknown natural disease process</u>
20c. TIME OF INJURY <u>3:00</u> Hour <u>AM</u> a.m. <u>2/18/60</u> Month, Day, Year		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>bedroom of home</u>	20f. CITY, TOWN, OR LOCATION <u>University City</u>	COUNTY <u>St. Louis</u>	STATE <u>Missouri</u>
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21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_, and last saw her/him alive on \_\_\_\_\_.  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Raymond H. Harris</u> (Degree or title) Coroner	22b. ADDRESS <u>Clayton, Mo.</u>	22c. DATE SIGNED <u>3/21/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/19/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beth Hamedrosh Hagodol</u>	23d. LOCATION (City, town, or county) <u>Ladue, Mo.</u>
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24. FUNERAL DIRECTOR <u>Berger Memorial 4715</u> ADDRESS <u>Clayton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-29-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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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. 3988

P. O. Address \_\_\_\_\_

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.