

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

**-60-017018**

**FILED VS. APR 2 9 1960**

**2, 3533**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>                 |  | Length of stay in 1b<br><b>30 yrs</b>  | c. CITY OR TOWN <b>Affton</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>9021 Mathilda</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |                      |                      |                         |   |                       |                  |                     |
|---|----------------------|----------------------|-------------------------|---|-----------------------|------------------|---------------------|
| 3. NAME OF DECEASED (Type or print)<br><b>RUTH ANN KIRCHNER</b> | First<br><b>RUTH</b> | Middle<br><b>ANN</b> | Last<br><b>KIRCHNER</b> | 4. DATE OF DEATH<br><b>March 26, 1960</b> | Month<br><b>March</b> | Day<br><b>26</b> | Year<br><b>1960</b> |
|---|----------------------|----------------------|-------------------------|---|-----------------------|------------------|---------------------|

|                         |                                  |   |                                    |                                     |  |                        |
|-------------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|------------------------|
| 5. SEX<br><b>female</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>9/23/29</b> | 9. AGE (last birthday)<br><b>30</b> | IF UNDER 1 YEAR<br>Months<br>Days<br>Hours | IF UNDER 24 HR<br>Min. |
|-------------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|------------------------|

|  |   |   |   |
|--|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife &amp; former sec'y</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>at home - Mfg</b> | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
|--|---|---|---|

|  |   |   |
|--|---|---|
| 13a. FATHER'S NAME<br><b>Francis A. Bock</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Florence Robein</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Wilbert L. Kirchner</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>488-30-9909</b> | 17. INFORMANT<br><b>Wilbert L. Kirchner, 9021 Mathilda, Affton</b> | Address |
|---|---|--|---------|

|   |  |   |  |
|---|--|---|--|
| 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>Intercranial Hemorrhage</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Rupture intercranial, arterial aneurysm</b><br>DUE TO (c) <b>330x</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 months</b><br><b>1 1/2 months</b> |  |   |  |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<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<br>COUNTY<br>STATE |
|--|--|---|

21. I attended the deceased from **2-5-60** to **3-26-60** and last saw her <sup>her</sup> <sub>him</sub> alive on **3-26-1960**  
Death occurred at **3:24 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

|  |  |                                    |
|--|--|------------------------------------|
| 22a. SIGNATURE<br><i>[Signature]</i> (degree or title) | 22b. ADDRESS<br><b>3576 Central, Clayton, Mo</b> | 22c. DATE SIGNED<br><b>3-28-60</b> |
|--|--|------------------------------------|

|   |                             |  |   |         |
|---|-----------------------------|--|---|---------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b> | 23b. DATE<br><b>3/29/60</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph Cemetery</b> | 23d. LOCATION (City, town, or county)<br><b>Pilot Grove, Missouri</b> | (State) |
|---|-----------------------------|--|---|---------|

|  |         |  |   |
|--|---------|--|---|
| 24. FUNERAL DIRECTOR<br><b>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.</b> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><b>MAR 28 1960</b> | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |
|--|---------|--|---|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. John S. Skinner,  
35 No. Central

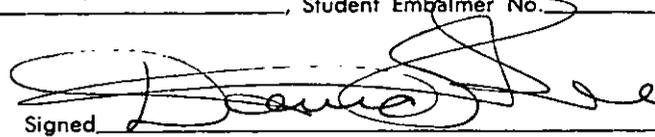
PA 6 - 0683 - 2-5-58  
92-3-5858

**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. 45  
P. O. Address St. Louis

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