URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAY 2 1960

60-017382

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 4197

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Park Lane Hosp.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3531 A Delor
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Louis Middle: E Last: Suhre
4. DATE OF DEATH: Month: April Day: 15 Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6/15/1891
9. AGE (last birthday): 68
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintainence
10b. KIND OF BUSINESS OR INDUSTRY: St. Louis House
11. BIRTHPLACE (City and state or country): Alhambra, Ill.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Ernst W. Suhre
13b. MOTHER'S MAIDEN NAME: Sophie Blomker
14. NAME OF HUSBAND OR WIFE: Louise Suhre
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Louise Suhre Address: 3531 A Delor

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerabral Hemorrage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 331 X
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 April 12, 1960 to April 15, 1960 I last saw her/him alive on April 15, 1960
Death occurred at Ten Thirty A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Frank J. Smith (Degree or title) M.D.
22b. ADDRESS: 4930 Lindell Blvd.
22c. DATE SIGNED: APR 18 1960

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1/18/60
23c. NAME OF CEMETERY OR CREMATORY: Park Lawn Cem.
23d. LOCATION (City, town, or county) (State): St. Louis County Mo.

24. FUNERAL DIRECTOR: Schumacher's ADDRESS: 3013 Meramec
25. DATE RECD. BY LOCAL REG.: APR 18 1960
26. REGISTRAR'S SIGNATURE: Karl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed Jack Haupt

Signature of Student Embalmer

Licensed Embalmer No. 474

P. O. Address S. Fam

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