

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017777

FILED VS MAY 6 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1313 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>New York</u> b. COUNTY <u>Kings</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Creve Coeur</u>	Length of stay in 1b <u>8 yrs.</u>	c. CITY OR TOWN <u>Brooklyn</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>Evergreens Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>678 68th St.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Christine</u> Middle <u>Russell</u> Last <u>Kefauver</u>			4. DATE OF DEATH Month <u>April</u> Day <u>20</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>1/7/1883</u>	9. AGE (last birthday) <u>77</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>Retired Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	11. BIRTHPLACE (City and state or country) <u>New York, N.Y.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>William P. Russell</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Nora O'Neal</u>		14. NAME OF HUSBAND OR WIFE <u>Lloyd A. Kefauver</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>None</u>	17. INFORMANT Address <u>Col. Lloyd A. Kefauver, 6820 Delmar</u>		

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>Pericardial failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>Apr. 1-24</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Intermyocardial</u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis & Semblity</u>		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 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 <u>8:50</u> a.m. <u>pm</u> Month, Day, Year <u>5-8 Jun 59</u>	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 5-8 Jun 59, to 4-20-60 and last saw her alive on 4-18-60
Death occurred at 8:50 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Dr. W. Schuman, M.D.</u>		22b. ADDRESS <u>4161 Lenox</u>	22c. DATE SIGNED <u>4-21-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-25-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Fort Meade, Va.</u>

24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>4-21-60</u>	26. REGISTRAR'S SIGNATURE <u>John S. 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 Melvin L. Kern

Licensed Embalmer No. 405-

P. O. Address 4911 NW
St. Louis

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