

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017919

FILED VS. APR 22 1960

Registration District No. 319

Primary Registration District No. 500

Registrar's No. 1133

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sappington		Length of stay in 1b YRS	c. CITY OR TOWN Sappington Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 12705 Sunset Dr.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 12705 Sunset Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Robert Middle H. Last Ridge			4. DATE OF DEATH Month April Day 2 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/20/1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	11. BIRTHPLACE (City and state or country) Dexter, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Newton Ridge		13b. MOTHER'S MAIDEN NAME Sarah King		14. NAME OF HUSBAND OR WIFE Nellie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Nellie Ridge, 12705 Sunset Dr.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO (b) Arteriosclerotic Heart disease with Myocardial Decompensation DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Thrombosis (old)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 _____ a.m. _____ 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 Jan. 1958 to April 2, 1960 and last saw her/him alive on March 30, 1960 Death occurred at 5:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE Joseph R. Muecke M.D. (Degree or title)	22b. ADDRESS 634 North Grand	22c. DATE SIGNED 4/5/60
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 4-6-60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24. FUNERAL DIRECTOR Harrison Sheahan, 4700 Washington Blvd. ADDRESS	25. DATE RECD. BY LOCAL REG. 4-5-60	26. REGISTRAR'S SIGNATURE John C. Murphy M.D. (State)

(Licensed Embalmer's Statement on Reverse Side)

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 Robert M. Maus

Licensed Embalmer No. 374
P. O. Address St. Louis

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.