RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 12 1960

-60-024867

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6461

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: 3937a Lafayette Ave.
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): 3937a Lafayette Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: CLARA Middle: FRANCES (Horen) Last: PREIS

4. DATE OF DEATH: Month: June Day: 24 Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 6-2-1897
9. AGE (last birthday): 63
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): Linen Matron-Fred Harvey Restaurants
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Riley Salsman
13b. MOTHER'S MAIDEN NAME: Rosa West
14. NAME OF HUSBAND OR WIFE: Late George Preis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 491-14-8181
17. INFORMANT: Florence Boyd Address: 10000 Ashbrook (37)

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): Coronary Thrombosis
DUE TO (b): Diabetes
DUE TO (c): none
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 260 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): none

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 1956 to 1960 and last saw her alive on 6/20/60
Death occurred at 6/24/60 2:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Preston C Hall MD (Degree or title)
22b. ADDRESS: 3902a Lafayette
22c. DATE SIGNED: 6/24/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal(Mtr)
23b. DATE: June 27,1960
23c. NAME OF CEMETERY OR CREMATORY: Wright City Cemetery
23d. LOCATION (City, town, or county) (State): Wright City, Mo.

24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S. Kingshighway Blvd.
25. DATE RECD. BY LOCAL REG.: JUN 24 1960
26. REGISTRAR'S SIGNATURE: Hoard Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 Geo. H. Kreipkauer, Jr.

Signature of Student Embalmer

Licensed Embalmer No. 4988

P. O. Address St. Louis

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