

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 2 9 1960

5494-60-024893 STATE FILE NUMBER

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

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b		c. CITY OR TOWN <u>University City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>7231 Northmoor Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>MOTT</u> Last <u>RHEIN</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>24</u> Year <u>1960</u>				
5. SEX <u>Male</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>9-2-1899</u>	9. AGE (last birthday) <u>60</u>	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) <u>Salesman-Mallinckrodt Chemical Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical Co.</u>		11. BIRTHPLACE (City and state or country) <u>Mt. Vernon, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles W. Rhein</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Mott</u>			14. NAME OF HUSBAND OR WIFE <u>Lucille Behslage Rhein</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>491-16-7996</u>		17. INFORMANT <u>Lucille B. Rhein 7231 Northmoor Dr.</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>Myocardial infarction, acute</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>421.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u> <u>1-2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>						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 checked="" type="checkbox"/> NO <input 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 <u>May 24, 1960</u> to <u>MAY 24, 1960</u> and last saw <u>her</u> <u>live</u> on <u>24 May, 1960</u> Death occurred at <u>9:20 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>James F. Nickel</u> (Degree or title) <u>M. D.</u>				22b. ADDRESS <u>BARNES HOSPITAL</u>			22c. DATE SIGNED <u>5/25/60</u>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Removal</u>		23b. DATE <u>May 27, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>			23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u> (State)		
24. FUNERAL DIRECTOR <u>Kriegshauser 9450 Olive St. Road</u>				25. DATE RECD. BY LOCAL REG. <u>MAY 26 1960</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> <u>mjb</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APPROVED 2/24/44

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 William B. White

Licensed Embalmer No. 429

P. O. Address _____

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.