URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ILED VS JUL 7 1960

NDED

-60-025390
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1855

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY ST. LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN AFFTON
Length of stay in 1b 2 Weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Miller Nursing Home
Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY ST. LOUIS
c. CITY OR TOWN AFFTON
Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 9119 DARLENE
Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First PAULINE Middle Last FULLER
4. DATE OF DEATH Month JUNE Day 16 Year 1960
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 9-22-1875
9. AGE (last birthday) 84
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) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (City and state or country) Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME WILLIAM KRAUS
13b. MOTHER'S MAIDEN NAME CHRISTINA STUCKLING
14. NAME OF HUSBAND OR WIFE EMIL FULLER
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. NONE
17. INFORMANT EMIL FULLER Address 9119 DARLENE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC FAILURE
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
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 JUNE 4 '60 to JUNE 15 and last saw her/him alive on JUNE 15, 1960
Death occurred at 2 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William Cochran M.D.
22b. ADDRESS 2800 a Chippewa
22c. DATE SIGNED 6-16-60

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE JUNE 18, 1960
23c. NAME OF CEMETERY OR CREMATORY S.S. PETER & PAUL CEM
23d. LOCATION (City, town, or county) ST. LOUIS (State) Mo.
24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois
25. DATE RECD. BY LOCAL REG. 6-17-60
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Signature of Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 St

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