

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 4 1960

318

1003

7136-60-028050
STATE FILE NUMBER

NDED

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA City Hosp. II		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5567 Maple Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Renee Middle Zoe Last Ahammer	4. DATE OF DEATH Month July Day 14 Year 1960
---	--

5. SEX female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 21 Apr. 1957	9. AGE (last birthday) 3	IF UNDER 1 YEAR Months 3 Days	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	---	------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXX	10b. KIND OF BUSINESS OR INDUSTRY XXXX	11. BIRTHPLACE (City and state or country) Weissbaden Germany	12. CITIZEN OF WHAT COUNTRY
--	--	---	-----------------------------

13a. FATHER'S NAME Irby Ahammer	13b. MOTHER'S MAIDEN NAME Harriet G. Neal	14. NAME OF HUSBAND OR WIFE XXXX
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, XXXX unknown) (If yes, give war or dates of service) XX	16. SOCIAL SECURITY NO. XXX	17. INFORMANT Irby Ahammer Address 5567 Maple
--	---------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	921.0-18

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Foreign body	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
--	---

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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) Spent bullet in left chest) was lodged in trachea at home
---	--	---

20c. TIME OF INJURY Hour 7 a.m. Month, Day, Year 14 60	an or about July 14 1960
---	---------------------------------

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.) 05 Home	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY STATE
--	--	--	--------------

21. I attended the deceased from **205 P.** and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick Taylor Curran	22b. ADDRESS 1300 Clark	22c. DATE SIGNED JUL 15 1960
--	-----------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 19 July 1960	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
---	----------------------------------	--	--

24. FUNERAL DIRECTOR Reliable Funeral Sys. 1389 N. Union	25. DATE RECD. BY LOCAL REG. JUL 16 1960	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
--	--	--

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 Flurence D. Brown

Licensed Embalmer No. 4758

P. O. Address 1389 W. 1st

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.