

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028420

FILED VS. AUG. 4 1960

318

Primary Registration District No. 1003

Registrar's No. 7195

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Length of stay in 1b		c. CITY OR TOWN <u>ST. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2928 University</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2928 University</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Herman</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1960</u>															
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-1885</u>		9. AGE (last birthday) <u>74</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>ST. Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>											
13a. FATHER'S NAME <u>J. P. Riechers</u>				13b. MOTHER'S MAIDEN NAME <u>Catherine Baker</u>				14. NAME OF HUSBAND OR WIFE <u>John B</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>None</u>		17. INFORMANT Name <u>Miss Lou Gais</u> Address <u>2928 University</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>Coronary thrombosis</u> DUE TO (b) <u>Coronary heart disease</u> DUE TO (c) <u>420.1</u> Condition if any which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>									
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. <input type="checkbox"/> Yes <input checked="" 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 Month, Day, Year a.m. p.m.		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>June 1946</u> to <u>July 18, 1960</u> and last saw her <u>alive</u> on <u>Mar. 1960</u> Death occurred at <u>11:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <u>Edward J. Kelberg M.D.</u> (Degree or title)						22b. ADDRESS <u>950 Francis Pl. Clayton</u>				22c. DATE SIGNED <u>7-18-60</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>7-21-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine</u>				23d. LOCATION (City, town, or county) (State) <u>ST. Louis Mo</u>											
24. FUNERAL DIRECTOR <u>A. Rou Hud Co 2707 N. Grand</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>JUL 19 1960</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>													

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

7195

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 Hector J. Gau Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 2

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.