

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028734

FILED VS AUG 4 1960

318 Primary Registration District No. 1003

Registrar's No. 7237

STATE FILE NUMBER

INDEXED

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1423 N. 11th St.</b>		d. STREET ADDRESS (If outside, give location) <b>1423 N. 11th St.</b>	

3. NAME OF DECEASED (Type or print) <b>CORNELIA I. RICHTER</b>			4. DATE OF DEATH Month Day Year <b>July 19th, 1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/3/1910</b>	9. AGE (last birthday) <b>50</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>George Hoerr</b>		13b. MOTHER'S MAIDEN NAME <b>Mae Knopf</b>		14. NAME OF HUSBAND OR WIFE <b>Harold Richter</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>	16. SOCIAL SECURITY NO. <b>493-20-9889</b>	17. INFORMANT <b>Harold Richter 1423 N. 11th St.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PARTIAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
DUE TO (b) <b>Cerebral Arteriosclerosis</b>		<b>3 years</b>
DUE TO (c) <b>332x</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension Cardiovascular Disease</b>		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	
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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 <b>July 1957</b> to <b>April 30, 1960</b> and last saw her alive on <b>April 30, 1960</b> Death occurred at <b>6:00 AM July 19, 1960</b> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <b>John A. Beard, M.D.</b>	22b. ADDRESS <b>9313 Mandeville Rd.</b>	22c. DATE SIGNED <b>7/20/60</b>
23a. BURIAL OR CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/22/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>
24. FUNERAL DIRECTOR <b>Central Funeral Home 1841 Cass Ave.</b>		23d. LOCATION (City, town, or county) (State) <b>Bellefontaine Neighbors, Mo.</b>

25. DATE RECD. BY LOCAL REG. <b>JUL 20 1960</b>	26. REGISTRAR'S SIGNATURE <b>Leon Smith, M.D.</b>
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BY AFFIDAVIT OF

7110

Dr. David John  
Medical Clinic  
Shinin, Oregon  
No. 22070

**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 *Orin R. [Signature]*

Licensed Embalmer No. 3980

P.O. Address St. Louis

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