

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JUL 26 1960 317

60-029211

Registration District No. 500 Primary Registration District No. 2130 Registrar's No. STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Koch</b>		Length of stay in 1b <b>216 days</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>809 Grand</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>ANN</b> Last <b>Davis</b>			4. DATE OF DEATH Month <b>7-</b> Day <b>14</b> Year <b>60</b>	
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-28-87</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printing Press Operator</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Joseph Davis</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Muir</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>494-01-6015</b>	17. INFORMANT <b>Medical Records, Robert Koch Hospital</b> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
DUE TO (b) <b>Hypertensive vascular syndrome (arteriosclerosis)</b>		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Healed I.T. Fracture of right femur. Chronic brain syndrome</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.) <b>Patient fell in street on 11-20-59.</b>
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20c. TIME OF INJURY Hour <b>11</b> a.m. <b>20</b> p.m. <b>59</b> Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	COUNTY <b>Missouri</b>	STATE
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21. I attended the deceased from <b>12-11-59</b> to <b>7-14-60</b> and last saw her alive on <b>7-14-60</b> Death occurred at <b>5:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Harold G. Howard, M.D.</i> (Degree or title)	22b. ADDRESS <b>Robert Koch Hospital, Koch, Mo.</b>	22c. DATE SIGNED <b>7-15-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>7-16-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE</b>	23d. LOCATION (City, town, or county) (State) <b>Belleville ILL. Nois</b>
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24. FUNERAL DIRECTOR <b>FINGER</b>	ADDRESS <b>MARISSA, ILL</b>	25. DATE RECD. BY LOCAL REG. <b>7-16-60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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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

*Frank Proff*

Licensed Embalmer No.

4356

P. O. Address

*St Louis Mo*

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.