

INDEXED

FILED VS. SEP. 2 1960

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

7313 STATE FILE NUMBER

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 St. Louis		Length of stay in 1b 5 Days	c. CITY OR TOWN Afton
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Luthern Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8017 Wynwood

3. NAME OF DECEASED (Type or print) HELEN	First	Middle	Last	4. DATE OF DEATH 7-22-1960	Month	Day	Year
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1896	9. AGE (last birthday) 1 83	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Henry Efken	13b. MOTHER'S MAIDEN NAME Elizabeth Nehe	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Rose Gujahr	Address 8017 Wynwood MO.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Fractured Skull	
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	Generalized Arterio sclerosis	
DUE TO (b)	9020	
DUE TO (c)		

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
21	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) Suffered in fall from
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20c. TIME OF INJURY Hour 7 a.m. Month, Day, Year 1866	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.) 3A Home	20f. CITY, TOWN, OR LOCATION St. Louis Mo.	COUNTY	STATE
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21. I attended the deceased from 8/10 A.M. to _____ and last saw her/him alive on _____
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Death occurred at **8/10 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title)	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 7-22-66
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23a. BURIAL CREMATION (Specify)	23b. DATE 7-24-1960	23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem.	23d. LOCATION (City, town, or county) St. Louis Mo.	(State)
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24. FUNERAL HOME Wagnermuelle	ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 22 1960	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFRAVIT 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

Geo. H. Kingham
Licensed Embalmer No. 4611

P. O. Address H. Louis

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.