

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-032793**

**FILED VS. AUG 24 1960**

**318**

Primary Registration District No.

**1003**

Registrar's No.

**8087**

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. Louis, Mo.</b>		Length of stay in lb <b>18 days</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>3815 Castleman Ave.</b> <del>0005000000000000</del>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>E.</b> Last <b>Rueckert</b>			4. DATE OF DEATH Month <b>8</b> Day <b>16</b> Year <b>60</b>					
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</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>6-3-1862</b>	9. AGE (last birthday) <b>98</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stayed home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Dietrich Rueckert</b>			13b. MOTHER'S MAIDEN NAME <b>Don't Know</b>			14. NAME OF HUSBAND OR WIFE		
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>no</b>		17. INFORMANT <b>Elise Rueckert</b>			Address <b>3815 Castleman</b>
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> DUE TO (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>443 x F</b> CONDITION, if any, which gave rise to stated cause (e.g., lying cause last.) <b>Joseph M. Ziem</b> <b>Joseph M. Ziem</b> <b>Joseph M. Ziem</b>							INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Fracture of neck of left femur</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 at her home</b>						
20c. TIME OF INJURY Hour <b>7</b> a.m. / p.m. Month, Day, Year <b>7-29-60</b>		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>17, in home</b>	20f. CITY, TOWN, OR LOCATION <b>3815 Castleman</b>		COUNTY <b>ST Louis, Mo</b>	STATE	
21. I attended the deceased from <b>July 29, 1960</b> to <b>Aug 16, 1960</b> and last saw her alive on <b>Aug 15, 1960</b> Death occurred at <b>6:30 A.M.</b> m on the date stated above, and to the best of my knowledge from the causes stated.								
22a. SIGNATURE <b>Robert E. Thomason M.D.</b> (Degree or title)				22b. ADDRESS <b>120 N Euclid</b>			22c. DATE SIGNED <b>8-16-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>8-17-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>		23d. LOCATION (City, town, or county) <b>ST. Louis Co Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Weick Bros 2201 S. Grand</b>				25. DATE RECD. BY LOCAL REG. <b>AUG 16 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

DOCUMENT

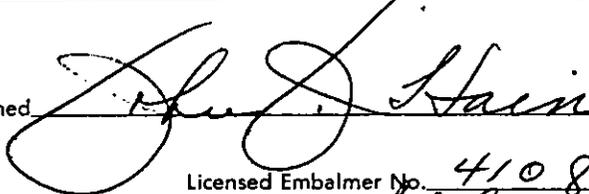
MEDICAL CERTIFICATION

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  \_\_\_\_\_

Licensed Embalmer No. 4108

P. O. Address St. 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.