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Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8274** -60-032818 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		Length of stay in lb 1 Mo.	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Claridge Hotel		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 1800 Ibeust Claridge Hotel
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First **Ruth** Middle **Ann** Last **Scher** 4. DATE OF DEATH Month **8** Day **21** Year **60**

5. SEX **Female** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **3/15/1923** 9. AGE (last birthday) **37**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Nurse** 10b. KIND OF BUSINESS OR INDUSTRY **Hospital** 11. BIRTHPLACE (City and state or country) **Louisiana, Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Earl B. Osborne** 13b. MOTHER'S MAIDEN NAME **Lourinda FISCHER** 14. NAME OF HUSBAND OR WIFE *********

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes** 16. SOCIAL SECURITY NO. **UNKNOWN** 17. INFORMANT **Lydia Kelly, Louisiana, Mo.** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Tubercular Edema**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **Cirrhosis of the Liver**

DUE TO (c) **Chronic Interstitial Nephritis**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **.5810**

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Patrick J. Taylor Coroner** 22b. ADDRESS **1300 Clark** 22c. DATE SIGNED **8.23.60**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **Aug. 23, 60** 23c. NAME OF CEMETERY OR CREMATORY **Fairview Cemetery** 23d. LOCATION (City, town, or county) (State) **Pike Co. Mo.**

24. FUNERAL DIRECTOR ADDRESS **COLLIER FUNERAL SERVICE** 25. DATE RECD. BY LOCAL REG. **AUG 23 1960** 26. REGISTRAR'S SIGNATURE **Earl Smith. M.D.**

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS SEP 2 - 1960

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. M. Collier

Licensed Embalmer No. 3839

P. O. Address Louisiana

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