

FILED VS. SEP 14 1960

318

Primary Registration District No. 1003

Registrar's No.

8719

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		c. CITY OR TOWN AFFTON	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LUTHERAN HOSP.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 11023 Ridge Forest	
3. NAME OF DECEASED (Type or print) First EDWARD Middle C. Last SEKTER				4. DATE OF DEATH Month SEPT Day 4 Year 1960			
5. SEX MALE	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 1-28-1896	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CONTRACTOR				10b. KIND OF BUSINESS OR INDUSTRY Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME AUGUST SEKTER			13b. MOTHER'S MAIDEN NAME MARY HELLER			14. NAME OF HUSBAND OR WIFE ANNA SEKTER (Doe. D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes w. w. I			16. SOCIAL SECURITY NO. 499-12-8470		17. INFORMANT Address MARY ANN COFFIN 11023 Ridge Forest		
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) Cerebro-vascular accident							3 months
DUE TO (b) arteriosclerotic hypertensive heart							3 yrs
DUE TO (c) decreased 4200							
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 type="checkbox"/> No <input type="checkbox"/> Unknown
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 p.m.	Month, Day, Year						
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 7/13/51 to 9/4/60 and last saw her alive on 9/4/60 Death occurred at 9:30p m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Paul Sawchuk MD (Degree or title)				22b. ADDRESS 5203 Chypp			22c. DATE SIGNED 9/6/60
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE SEPT 8 1960	23c. NAME OF CEMETERY OR CREMATORY ST. MARTIN CEM.		23d. LOCATION (City, town, or county) High Ridge Mo		(State)	
24. FUNERAL DIRECTOR Thomas Katis 2906 Buena			25. DATE RECD. BY LOCAL REG. SEP 6 1960		26. REGISTRAR'S SIGNATURE Loal Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

RM 202
12-3 9m

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 gra

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