

I & R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS/SEP 7 1960

60-033245

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 2555 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 b. COUNTY St. Louis					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maplewood 17		Length of stay in lb 1 Month		c. CITY OR TOWN University City 30,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Maplewood Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 504 Kingsland Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last MRS. EMMA EHLHARDT RUPP				4. DATE OF DEATH Month Day Year August 27, 1960					
5. SEX F.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/30/1872	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Phillip Ehlhardt			13b. MOTHER'S MAIDEN NAME Caroline M. Spangenberg			14. NAME OF HUSBAND OR WIFE Jacob Rupp			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Howard G. Rupp 8710 Antler Dr. (17)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) fracture left hip					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				
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.) fell at home					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 7-3-60									
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.) home		20f. CITY, TOWN, OR LOCATION St. Louis		COUNTY Mo.		STATE	
21. I attended the deceased from 7-15-60 to 8-27-60 and last saw her alive on 7-29-60 Death occurred at 8-27-60 4:30 P on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) W. Edward Lonsche, M.D.				22b. ADDRESS 41 North Central, Clayton (5)			22c. DATE SIGNED 8/29/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 8/30/1960	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri				
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons 6175 Delmar Blvd.				25. DATE RECD. BY LOCAL REG. 8-29-60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. W. Edward Lansche

41 No. Central Ave

Pa. 5-8444

1 to 5 P.M.

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. 4253

P. O. Address _____

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.