

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH =60-036392

FILED VS. SEP 21 1960

318

1003

8962

STATE FILE NUMBER

| | | | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY - - - - | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY - - - - | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | Length of stay in lb Lifetime | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 2146A Farrar Street 5351X DELAWARE BLVD | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First Katie E. RECK Last Miller | | | | 4. DATE OF DEATH Month Sep't. Day 10 Year 1960 | | | | | | | |
| 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 2/9/77 | | 9. AGE (last birthday) 83 | | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Garment Worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY = = = | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | | | |
| 13a. FATHER'S NAME John A. Reckart | | | | 13b. MOTHER'S MAIDEN NAME Mary Jane Lodlow | | | | 14. NAME OF HUSBAND OR WIFE Charles F. Miller | | | |
| 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. 497-07-4216 | | 17. INFORMANT Stanley Miller, Imperial, Missouri | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heat Exhaustion | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 72 hours | | | |
| DUE TO (b) Arteriosclerosis, generalized, severe | | | | | | | | Unknown | | | |
| DUE TO (c) 450-DF | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None | | | | | | | | 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.) Does not apply | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. None | | 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 9/29/58 , to 9/9/60 and last saw her/him alive on 9/9/60 | | | | Death occurred at 5:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Harold E. Walters M.D. | | | | 22b. ADDRESS 3720 Washington St. Louis Mo. | | | | 22c. DATE SIGNED 9-10-60 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 9-13-60 | | 23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery | | 23d. LOCATION (city, town, or county) St. Louis County, Missouri | | | | | |
| 24. FUNERAL DIRECTOR ALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, St. Louis, 15, Missouri. | | | | 25. DATE RECD. BY LOCAL REG. SEP 12 1960 | | 26. REGISTRAR'S SIGNATURE Roal Smith, M.D. | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Handwritten notes:
OK
Paul
Sept 10 1960
Conditions if any, which gave rise to above cause (a), being the underlying cause last.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Ralph C. Linder

Licensed Embalmer No. 42

P. O. Address St. Louis

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.