

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS OCT 1 0 1960

-60-036769
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 2855

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u> | | c. CITY OR TOWN <u>University City</u> | |
| Length of stay in 1b <u>YRS</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6751 A. Crest Ave.</u> | | d. STREET ADDRESS (If outside, give location) <u>6751 A. Crest Ave.</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CAROLINE WASHFORD</u> | | | 4. DATE OF DEATH Month Day Year <u>Sept. 28, 1960</u> | | |
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| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-29-1874</u> | 9. AGE (last birthday) <u>86</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | 11. BIRTHPLACE (City and state or country) <u>Aviston, Ill.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>John Washford</u> | 13b. MOTHER'S MAIDEN NAME <u>Tressa Luethjohn</u> | 14. NAME OF HUSBAND OR WIFE <u>none</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT <u>Mrs. Katie Herr</u> | Address <u>U. City Mo. 6751 A. Crest Ave.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> |
| DUE TO (b) <u>Senility</u> | | |
| DUE TO (c) | | <u>?</u> |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | | 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 | |
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| 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.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year |
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| 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 |
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21. I attended the deceased from Jan. 1960 to 28 Sept 1960 and last saw her alive on 26 Sept. 1960
Death occurred at 5:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>John W. Magness</u> (Degree or title) | 22b. ADDRESS <u>University City Mo.</u> | 22c. DATE SIGNED <u>28 Sept 60</u> |
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| 23a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>Funeral</u> | 23b. DATE <u>9-30-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons</u> | ADDRESS <u>7233 Delmar Bly'd.</u> | 25. DATE RECD. BY LOCAL REG. <u>9-28-60</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Mumfley M.D.</u> |
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arnold W. Sch

Licensed Embalmer No. 386

P. O. Address St. Louis

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