

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-036881**

FILED VS OCT 1 0 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 2794

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ferguson</b>		Length of stay in lb <b>D.O.A.</b>	c. CITY OR TOWN <b>Berkeley</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>111 Church Street</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8041 January Avenue</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>OZETTA</b> Last <b>DORRIS</b>			4. DATE OF DEATH Month <b>9</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 21, 1888</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b>	IF UNDER 24 HR Hours <b>15</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fleming Dealoge Hosp</b>		11. BIRTHPLACE (City and state or country) <b>Pilot Knob, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Joseph Newton Beard</b>		13b. MOTHER'S MAIDEN NAME <b>Rebecca Warner</b>		14. NAME OF HUSBAND OR WIFE <b>deceased</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>492-30-0649</b>	17. INFORMANT <b>Mr. Jack Holton, 8041 January Avenue</b>	Address <b>8041 January Avenue</b>
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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) <b>Cerebrovascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic cerebrovascular disease</b>		<b>15 yrs</b>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ASHA with auricular fibrillation</b>		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.)	
20c. TIME OF INJURY Hour <b>5:25</b> Month, Day, Year <b>9/19/60</b>	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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from <b>12/14/57</b> to <b>9/19/60</b> and last saw her/him alive on <b>9/19/60</b> Death occurred at <b>5:25</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>James D. Jolly M.D.</b>	22b. ADDRESS <b>111 Church Ferguson, Mo</b>	22c. DATE SIGNED <b>9/20/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-22-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Park Cemetery</b>
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc., 2161 E. Fair</b>	25. DATE RECD. BY LOCAL REG. <b>9-20-60</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>

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 my self, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Reinhold K. Lohrm

Licensed Embalmer No. 339

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.