URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-038798

STATE FILE NUMBER

FILED VS OCT 21 1960

AMENDED

Registration District No. 160 Primary Registration District No. 3049 Registrar's No. 126

1. PLACE OF DEATH
a. COUNTY: Jefferson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Crystal City.
Length of stay in 1b: 78 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 209 Virginia Ave.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: Jefferson
c. CITY OR TOWN: Crystal City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 209 Virginia Ave.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: L ena Middle: Ann Last: LaRose
4. DATE OF DEATH: Month 10 Day 8 Year 60
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8/13/82
9. AGE (last birthday): 78
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): Festus MO
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: Louis Pfeil
13b. MOTHER'S MAIDEN NAME: E. Cook
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Viola Carron Address: Crystal City Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Complete heart Block — INTERVAL BETWEEN ONSET AND DEATH: 8 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis & Diabetes — 5 yrs
DUE TO (c):
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 4/5/49 to 10/8/60 and last saw her/him alive on 10/8/60
Death occurred at 8:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: [signature] (Degree or title): MD
22b. ADDRESS: Herculaneum Mo
22c. DATE SIGNED: 10/10/60
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/11/60
23c. NAME OF CEMETERY OR CREMATORY: Roselawn Cemetery
23d. LOCATION (City, town, or county) (State): Crystal City, Mo.
24. FUNERAL DIRECTOR ADDRESS: Politte Funeral Home Crystal City, Mo.
25. DATE REC'D BY LOCAL REG.: 10-10-60
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 348

P. O. Address _____

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