RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS OCT 26 1960 318 1003 9977 -60-040220

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST LOUIS — Length of stay in 1b: 2 WEEKS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST JOHN'S HOSPITAL — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI — b. COUNTY: ST. LOUIS
c. CITY OR TOWN: UNIVERSITY CITY — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 7124 FORSYTH — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: GERTRUDE — Middle: FRANCES — Last: SEARS
4. DATE OF DEATH: Month: OCT — Day: 13 — Year: 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 10/8/1894
9. AGE (last birthday): 66
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): AT HOME
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (City and state or country): SAN FRANCISCO, CALIF
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: CHARLES GREEN
13b. MOTHER'S MAIDEN NAME: MARGARET ROTCHFORD
14. NAME OF HUSBAND OR WIFE: GEORGE G SEARS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS J.C. MOLONEY — Address: 15 SUSSEX DR

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia - bilateral (Friedlanders) — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 490 X F

OK Joseph Moore M.D. Deputy Coroner 10/17/60

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Fracture of 6-7 ribs on left

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.): Fell at home
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 9-25-1960
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.): Home
20f. CITY, TOWN, OR LOCATION: University City — COUNTY: St Louis — STATE: Mo.

21. I attended the deceased from Sept 25, to Oct 13 and last saw her/him alive on Oct 12
Death occurred at 2:30 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): George A. Mahe M.D.
22b. ADDRESS: 950 Francis Pl.
22c. DATE SIGNED: 10-14-60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: OCT 15, 1960
23c. NAME OF CEMETERY OR CREMATORY: RESURRECTION CEMETERY
23d. LOCATION (City, town, or county) (State): ST LOUIS MISSOURI

24. FUNERAL DIRECTOR: STOCK MORTUARY — ADDRESS: 8895 BRENTWOOD
25. DATE RECD. BY LOCAL REG.: OCT 14 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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_____ Signed Paul A. Wacht

Signature of Student Embalmer

Licensed Embalmer No. 478

P. O. Address

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.