

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040519

FILED VS OCT 24 1960

317

Primary Registration District No. 542

Registrar's No. 2980

STATE FILE NUMBER

| | | | | | |
|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY SR LOUIS | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FERGUSON | | Length of stay in 1b YRS. | c. CITY OR TOWN FERGUSON | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 357 SO. DADE AVE | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (if outside, give location) 357 SO. DADE AVE | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Ahrens Last Ahrens | | | 4. DATE OF DEATH Month 10 Day 12 Year 1960 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widow <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6/4/1882 | 9. AGE (last birthday) 78 | IF UNDER 1 YEAR Months Days 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 HOME | 11. BIRTHPLACE (City and state or country) ST LOUIS MISSOU I | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME FRANK GESCHKE | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | 14. NAME OF HUSBAND OR WIFE unk. | |
| 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. NONE | | 17. INFORMANT Address MILDRED SCOLA 357 SO DADE AVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO (b) Arterio-sclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days 5 years |
| 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. <input type="checkbox"/> Yes <input 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.) | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 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 8-11-60 and last saw her/him alive on 10-12-60 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Quinn N. Kohl, M.D. | | 22b. ADDRESS 601 S. Brentwood, Clayton | | 22c. DATE SIGNED 10-12-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 10/15/60 | 23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEMETERY | | 23d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI |
| 24. FUNERAL DIRECTOR STROOT - CARROLL 4600 NATURAL BRIDGE AVE | | 25. DATE RECD. BY LOCAL REG. 10-13-60 | | 26. REGISTRAR'S SIGNATURE J. B. Amundson, M.D. | |

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 by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *[Handwritten Signature]*

Licensed Embalmer No. 4865
P. O. Address *[Handwritten Address]*

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