

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 24 1960

-60-040574
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3035

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>Normandy</u>		Length of stay in lb <u>DAYS</u>		c. CITY OR TOWN <u>Woodson Terrace</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>Normandy Osteopathic</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4112 Edmundson Rd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Selena</u> Middle <u>Anders</u> Last <u>Anders</u>				4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>60</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-29-1880</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased</u>		
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>Frank Anders</u> Address <u>4112 Edmundson Rd.</u>				
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>Respiratory Failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Atherosclerotic Encephalomalacia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>2 days.</u>	
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 checked="" 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 <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u> <u> </u> <u> </u>						
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 <u>10-5-60</u> to <u>10-15-60</u> and last saw <u>her</u> alive on <u>10-14-60</u> Death occurred at <u>7:00</u> <u>d.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>W Martin Elger M.D.</u>				22b. ADDRESS <u>8321 N. Broadway</u>		22c. DATE SIGNED <u>10/15/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-15-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Vincent Cemetery</u>		23d. LOCATION (City, town, or county) <u>Morrilton, Ark.</u>				
24. FUNERAL DIRECTOR <u>Jos. W. Clark F.H. 1125 Hodiamont</u>				25. DATE RECD. BY LOCAL REG. <u>10-18-60</u>		26. REGISTRAR'S SIGNATURE <u>John M. Maffly M.D.</u>		

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 John J. Harris
Licensed Embalmer No. 4108

P. O. Address Atlanta

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