

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-044695

FILED VS NOV 17 1960

DED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3177 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Koch, Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Missouri</u>		Length of stay in 1b <u>4 days</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		Inside Deaths Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4220 Bates</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Behre</u> Last			4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>60</u>	
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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>12-17-79</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Nil</u>	11. BIRTHPLACE (City and state or country) <u>Memphis, Tenn</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Harris</u>	13b. MOTHER'S MAIDEN NAME <u>Jennie Williams</u>	14. NAME OF HUSBAND OR WIFE <u>George Behre</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>492-16-0080</u>	17. INFORMANT <u>Records Robert Koch Hospital</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Probable Cerebral Thrombosis</u>		<u>1 day</u>
DUE TO (b) <u>Traumatic Fracture??</u>		<u>904.0-21</u> <u>1 month</u>
DUE TO (c) <u>Generalized Arteriosclerosis</u>		<u>??</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>I.T. Fracture of Left Hip; Ex of Lt Humerus</u>		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 checked="" 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.) <u>01 pt fell at home on 9-27-60</u>
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20c. TIME OF INJURY Hour <u>9</u> a.m. <u>27</u> p.m. <u>60</u> Month, Day, Year
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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.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo</u>	COUNTY	STATE
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21. I attended the deceased from <u>10-25-60</u> to <u>10-31-60</u> and last saw her/him alive on <u>10-31-60</u> Death occurred at <u>1:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Harold G. Russell</u> (Degree, title)	22b. ADDRESS <u>Robert Koch Hospital</u>	22c. DATE SIGNED <u>10-31-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>11/3/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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24. FUNERAL DIRECTOR <u>McLaughlin, 2301 Lafayette(4)</u>	25. DATE RECD. BY LOCAL REG. <u>11-2-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision;

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

Signed H. G. Farris

Licensed Embalmer No. 338  
P. O. Address St. Louis

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.