RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 17 1960

60-044704

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3138

1. PLACE OF DEATH a. COUNTY: St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo. b. COUNTY:
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Lemay — Length of stay in 1b: 7 Yrs.	c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Torrence Nursing Home — Inside Limits: Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location): 6220 Hancock Ave. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First: CECELIA	Middle:	Last: CONDER	4. DATE OF DEATH: Month Oct. Day 28 Year 1960
5. SEX: Female	6. COLOR OR RACE: White	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH: 11-20-1871	9. AGE (last birthday): 88 — 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): Housework	10b. KIND OF BUSINESS OR INDUSTRY: At Home	11. BIRTHPLACE (City and state or country): St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13a. FATHER'S NAME: Joseph Diener	13b. MOTHER'S MAIDEN NAME: Ida Amalia Kremer	14. NAME OF HUSBAND OR WIFE: Late Freeman Conder		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None	16. SOCIAL SECURITY NO.: None	17. INFORMANT: William J. Conder — Address: 6727 Sutherland		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 11 yrs +

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Arterio Sclerotic Heart Disease 420.0 — 11

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 12/3/53, to Oct 27 60 and last saw her/him alive on 10/27/60

Death occurred at 9:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William F McNamee MD	22b. ADDRESS: 7619a Troy Ave	22c. DATE SIGNED: 10/29/60
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 31, 1960	23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.		
24. FUNERAL DIRECTOR: Kriegshauser — ADDRESS: 4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG.: 10-29-60	26. REGISTRAR'S SIGNATURE: John C. Murphy Md.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4533

P. O. Address_____

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