

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2620 LAFAYETTE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2620 LAFAYETTE</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>WESTING</u> Last			4. DATE OF DEATH Month <u>DEC</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 12, 1876</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months Days Hours Min.
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>MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>	
13a. FATHER'S NAME <u>JOSEPH SCHELBRINK</u>		13b. MOTHER'S MAIDEN NAME <u>APOLLONIA BIETSCH</u>		14. NAME OF HUSBAND OR WIFE <u>FRED J. WESTING SR.</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>FRED J. WESTING JR RT 2. HIGH RIDGE MO</u> Address	

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>Chronic Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Generalized Arteriosclerosis</u>	
		DUE TO (c) <u>422.1</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 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 <u>October 1, 1960</u> to <u>December 14, 1960</u> and last saw her <u>alive on December 15, 1960</u> Death occurred at <u>12:40 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Thomas F. Summers, M.D.</u>			22b. ADDRESS <u>2264 S. Compton, St. Louis</u>		22c. DATE SIGNED <u>12/16/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC 19, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER + PAUL CEM.</u>		23d. LOCATION (City, town, or county) <u>ST. LOUIS MO.</u>	(State)
24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>DEC 19 1960</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.  
Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James O. [Signature]

Licensed Embalmer No. 434  
P. O. Address 2906 K

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.