

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-048315**

FILED VS JAN 16 1967

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3788 STATE FILE NUMBER

DED

|  |  |   |  |   |   |  |   |   |                                    |   |  |                              |  |
|--|--|---|--|---|---|--|---|---|------------------------------------|---|--|------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>                |   |  |   |   |                                    |   |  |                              |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>Manchester</b>  |  | Length of stay in 1b  |  | c. CITY OR TOWN <b>Manchester</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |   |                                    |   |  |                              |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>1155 Manchester Rd.</b>  |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>     |   | d. STREET ADDRESS (If outside, give location)<br><b>1155 Manchester Rd.</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |                                    |   |  |                              |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Bante</b> Last  |  |   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>30</b> Year <b>1960</b>  |   |  |   |   |                                    |   |  |                              |  |
| 5. SEX<br><b>female</b>  |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>5-2-1872</b>  |   | 9. AGE (last birthday)<br><b>88</b>   |                                    | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HR<br>Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>at home</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis Missouri</b>     |  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |                                    |   |  |                              |  |
| 13a. FATHER'S NAME<br><b>Carl Bante</b>  |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Katherine Gamp</b>  |   |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>none</b>  |                                    |   |  |                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no none</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   | 17. INFORMANT Address<br><b>Miss Vera Kuehne 1155 Manchester</b>                     |   |   |                                    |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Unknown Natural Cause</u><br>DUE TO (b)<br>DUE TO (c)<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |   |   |  |   |   |                                    | INTERVAL BETWEEN ONSET AND DEATH          |  |                              |  |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |                                    |   |  |                              |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour<br>a.m.<br>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 _____, to _____ and last saw her/him alive on _____<br>Death occurred at <u>8:18A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |   |   |  |   |   |                                    |   |  |                              |  |
| 22a. SIGNATURE (Degree or title)<br><i>John C. Murphy M.D.</i><br><b>John C. Murphy MD Asst. Health Commissioner</b>   |  |   |  |   |   | 22b. ADDRESS<br><b>801 S. Brentwood Clayton, Mo.</b>                                 |   |   | 22c. DATE SIGNED<br><b>1-10-61</b> |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Dec. 31, 1960</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Friedens Cemetery</b>  |   |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County Missouri.</b>    |   |                                    |   |  |                              |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>C.R. Lupton and Sons 7233 Delmar</b>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>12-30-60</b>   |   | 26. REGISTRAR'S SIGNATURE<br><i>John C. Murphy M.D.</i>                              |   |   |                                    |   |  |                              |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Miss Mary Bente  
Do. Vice

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 Clarence H. M.

Licensed Embalmer No. 401

P. O. Address St. Louis

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.