MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-010791
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2903

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis — Length of stay in 1b

c. CITY OR TOWN St.Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St.Luke's Hospital — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 5281 Washington — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Anna Middle Frances Last Forrest

4. DATE OF DEATH Month March Day 25, Year 1961

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒

8. DATE OF BIRTH 8/30/1886

9. AGE (last birthday) 74 — 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) Retired Saleslady

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Kentucky

12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME James Forrest

13b. MOTHER'S MAIDEN NAME Hedy Craig

14. NAME OF HUSBAND OR WIFE Fred Geiger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Mrs.Carl F.Schneider, Address Park Plaza Hotel

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 2 hrs.

DUE TO (b) Arteriosclerotic Heart Disease — 3 years

DUE TO (c) 420.0

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

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 1958, to 3/25/61 and last saw her alive on 2/15/61
Death occurred at 6:55 PM 3/25/61 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Hugh R. Waters M.D.

22b. ADDRESS 600 Union Blvd.

22c. DATE SIGNED 3/27/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 3-30-61

23c. NAME OF CEMETERY OR CREMATORY St.Mary's Cemetery

23d. LOCATION (City, town, or county) (State) Carlyle, Ill.

24. FUNERAL DIRECTOR ADDRESS Albert H.Hoppe, Inc., 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG. MAR 27 1961

26. REGISTRAR'S SIGNATURE MJB Carl Smith M.D.

DATE AMENDED 2

INSTEAD OF

SHOULD READ

ITEM NO.

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 by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed: Stanley H. Dufour

Licensed Embalmer No. #193

P. O. Address St. L.

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.