

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-010910

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3408**

STATE FILE NUMBER

**FILED APR 14 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>St. Louis.</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP.#1</b>		d. STREET ADDRESS (If outside, give location) <b>5800 Arsenal, St.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>LYDIA</b> First Middle <b>HAHN</b> Last	4. DATE OF DEATH <b>APRIL 8</b> Day <b>1961</b> Year
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/3/1887</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Henry Rindfliesch</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret (Unknown)</b>	14. NAME OF HUSBAND OR WIFE <b>Theophilus</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>Nil.</b>	17. INFORMANT <b>Theophilus John Hahn, 1318a Chambers, St.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>		
DUE TO (b) <b>Generalized arteriosclerosis</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>Hematuria, etiology unknown.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331X</b>		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.) <b>331X</b>
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED 1. WHILE AT WORK <input type="checkbox"/> 2. NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from <b>3/29/61</b> to <b>4/8/61</b> and last saw her/him alive on <b>4/8/61</b> Death occurred at <b>8:45 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Robert M. Aloush, M.D.</b>	22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	22c. DATE SIGNED <b>4/8/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4-11-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington,</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>APR 10 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 m

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed W. W. Wilkinson

Licensed Embalmer No. 3571

P. O. Address Low

**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.