

**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-016012**

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 941

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>Normandy</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Marys Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7626 Natural Bridge Rd.</b>

3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>PADIEN</b> Last <b>RICHTER</b>			4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1961</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1883</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>New York USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Bernard Padien</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Early</b>		14. NAME OF HUSBAND OR WIFE <b>George Richter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Claire O'Meara #9 Winding Brook (24)</b>		

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

IMMEDIATE CAUSE (a) *Senile atrophic ulceration of the stomach, cause unknown*

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) *E*

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
*Genl. arteriosclerosis*

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.		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 4-4-61 to 4-5-61 and last saw her/him alive on 4-5-61  
Death occurred at 8:55 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>John A. Muehle, M.D.</i>		22b. ADDRESS <i>950 Francis Pl. Clayton, Mo</i>		22c. DATE SIGNED <i>4-6-61</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>April 6, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Anastasia Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Harriman, New York</b>	
24. FUNERAL DIRECTOR ADDRESS <i>A. Lafanter &amp; Sons 6175 Delmar</i>		25. DATE RECD. BY LOCAL REG. <i>4-6-61</i>	26. REGISTRAR'S SIGNATURE <i>John C. Murphy, M.D.</i>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

Dr. John A Nuetzel  
950 Francis  
Pa 6 1126

1:30 - 400

**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

*Joseph E. McCallister*

Licensed Embalmer No. 2460

P. O. Address 618 1/2 Elm

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.