

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018965

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4907**

STATE FILE NUMBER

AMENDED

FILED JUN 8 1961

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 8669 Oriole Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First ADALINE Middle _____ Last FALLETT			4. DATE OF DEATH Month May Day 23 Year 1961					
5. SEX Female	6. COLOR OR RACE "hite"	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-18-1897	9. AGE (last birthday) 64	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Robert Marsella			13b. MOTHER'S MAIDEN NAME Theresa Rosso			14. NAME OF HUSBAND OR WIFE Clifford D. Fallert		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) *****			16. SOCIAL SECURITY NO. None			17. INFORMANT Address Clifford Fallert 8669 Oriole Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure (b) Atrial Fibrillation (c) 433.1 Conditions, if any, which gave rise to above cause (a), (b) or (c) (If the underlying cause is) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Probably late Embolic Phenomena especially to Femoral Ar						INTERVAL BETWEEN ONSET AND DEATH 6 hrs. Probably Mos.		
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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		
21. I attended the deceased from 12:15 PM 5-23-61 to 3 PM 5-23-61 and last saw her alive on 5-23-61 Death occurred at 9 PM on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Melvin Less M.D.				22b. ADDRESS 4118 West Florissant Ave		22c. DATE SIGNED 5-23-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/26/1961		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Mo.		
24. FUNERAL DIRECTOR JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.				25. DATE RECD. BY LOCAL REG. MAY 24 1961		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

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 *J. M. Ruster*

Licensed Embalmer No. 3980

P. O. Address St. Louis, Mo

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.