SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-022528
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5314

FILED JUN 16 1961

DATE AMENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.
Length of stay in 1b 15 yrs. 7 mo. 12 days.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital
Inside Limits Yes ☒ No ☐

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 ☒ No ☐
d. STREET ADDRESS (If outside, give location) from City Infirmary 5400 Arsenal St.
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First RALPH Middle Last FARLEY
4. DATE OF DEATH Month June Day 3rd, Year 1961
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 2-18-84 ?
9. AGE (last birthday) 77 yrs.
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) Nil
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE —
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. —
17. INFORMANT Marie Rothwell Address 4140 Lindell Blvd.

INSTEAD OF

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive bilateral aspiration pneumonia with abscesses — INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Fibrino-purulent peritonitis
DUE TO (c) 576x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Acute pyelonephritis with necrosis of kidneys. Mental deficiency
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 10-22-45, to 6-3-61 and last saw ~~her~~ him alive on 6-3-61
Death occurred at 5:30 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thomas Thale, M.D. Thomas Thale MD
22b. ADDRESS 5400 Arsenal St.
22c. DATE SIGNED 6-5-61

SHOULD READ

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 6-7-61
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Cullen & Kelly ADDRESS 7267 Natural Bridge
25. DATE RECD. BY LOCAL REG. JUN 7 1961
26. REGISTRAR'S SIGNATURE Hoard Smith, M.D.

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

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 Not Embalmed, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James A. Lammers

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.