

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=61-022814

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6289**

AMENDED

FILED JUL 13 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		c. CITY OR TOWN	
Length of stay in 1b <i>1 wk</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. John's Hospital</i>		d. STREET ADDRESS (If outside, give location) <i>20 Chamade Drive</i>	
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) First <i>Ann</i> Middle <i>Krieger</i> Last			4. DATE OF DEATH Month <i>7</i> Day <i>4</i> Year <i>61</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>1/12/1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <i>80</i>
11. BIRTHPLACE (City, and state or country) <i>St. Louis, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>John Butler</i>		13b. MOTHER'S MAIDEN NAME <i>don't know</i>	14. NAME OF HUSBAND OR WIFE <i>William S.</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		17. INFORMANT <i>Mrs. M. L. Tegerhoff</i>	
16. SOCIAL SECURITY NO.		Address <i>20 Chamade Dr.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Bronchial Asthma (Intrinsic Type)</i>			<i>6 yrs</i>
DUE TO (c) <i>24ix</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Generalized Arteriosclerosis</i>			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 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 a.m. p.m.	Month, Day, Year		
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 <i>15 Aug 55</i> to <i>3 July 61</i> and last saw her ^{him} alive on <i>3 July 61</i> Death occurred at <i>4:00 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John J. McClam M.D.</i>		22b. ADDRESS <i>4401 Hampton</i>	22c. DATE SIGNED <i>5 July 61</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>7/7/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>	23d. LOCATION (City, town, or county) (State) <i>Florissant, Mo.</i>
24. FUNERAL DIRECTOR <i>Jos. P. Howard</i>		ADDRESS <i>1619 So. Grand</i>	25. DATE RECD. BY LOCAL REG. <i>JUL 6 1961</i>
26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>			

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. W. Dinkley

Licensed Embalmer No. 3253

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.