

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-023577
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1749

FILED JUL 5 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Town and Country</u>		Length of stay in 1b <u>Y.P.S.</u>	c. CITY OR TOWN <u>Town and Country</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>12318 Crystal View La.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>12318 Crystal View La.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>L.</u> Last <u>RELF.</u>	4. DATE OF DEATH Month <u>June</u> Day <u>22</u> , Year <u>1961</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1870</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Clerk City of New Orleans</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>New Orleans La.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Stephen Zacharie Relf</u>	13b. MOTHER'S MAIDEN NAME <u>Frances Stirling Cammack</u>	14. NAME OF HUSBAND OR WIFE <u>Maud Tanner Relf</u>
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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) <u>yes</u>	16. SOCIAL SECURITY NO. <u>Spanish Amec. War</u>	17. INFORMANT <u>Mrs. John L. Sanders 12318 Crystal View La.</u>
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18. CAUSE OF DEATH (After only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
IMMEDIATE CAUSE (a) <u>Suffocation</u>		
DUE TO (b) <u>Hypostatic & Circulatory Congestion</u>		
DUE TO (c) <u>Cardiac Vascular Disease</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>thorax deformity and malnutrition</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u>2:00</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> Month, Day, Year <u>Feb. 4, 1960</u>	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 <u>St. Louis 41, Mo.</u>	COUNTY <u>St. Louis</u>	STATE <u>Mo.</u>
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21. I attended the deceased from <u>Feb. 4, 1960</u> to <u>June 13, 1961</u> and last saw ^{her} him alive on <u>June 13, 1961</u> Death occurred at <u>2:00 P.M.</u> 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) <u>William Seibert, D.O.</u>	22b. ADDRESS <u>12012 Olive St. Rd. St. Louis 41, Mo.</u>	22c. DATE SIGNED <u>6/23/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (rail) June 23, 1961</u>	23b. DATE <u>June 23, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Mausoleum</u>	23d. LOCATION (City, town, or county) (State) <u>New Orleans La.</u>
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24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons 7233 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>6-23-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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DATE AMENDED: 8/28/61
INSTEAD OF: Divorced
DOCUMENT: DOCUMENT
MEDICAL CERTIFICATION: MEDICAL CERTIFICATION
BY AFFIDAVIT OF: Fun. Dir.
ITEM NO.: 7
SHOULD READ: Married

Dec. 1910

County, Miss

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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 Arnold W. Schoene

Licensed Embalmer No. 3864

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.