

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035422
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2715

AMENDED

ED OCT 9 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</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>Rock Hill</u>	Length of stay in lb <u>5 Years</u>	c. CITY OR TOWN <u>Mt. Louis</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>Rock Hill Nursing Home</u>	Inside Limits No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7401 Parkdale</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Sabina</u> Middle <u>Price</u> Last <u>Price</u>			4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>61</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-1871</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kept House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>	11. BIRTHPLACE (City and state or country) <u>Ireland</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Mr. Henry</u>		13b. MOTHER'S MAIDEN NAME <u>Don't know</u>		14. NAME OF HUSBAND OR WIFE <u>Gustave Price</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Mrs. H.F. Williams 7401 Parkdale</u>
---	--------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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 <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 July 25, 1961 to Sept. 25, 1961 and last saw her alive on Sept. 23, 1961
Death occurred at 12:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert Sanders M.D.</u>	22b. ADDRESS <u>1502 Cass Av. St. Louis</u>	22c. DATE SIGNED <u>9-25-61</u>
--	--	------------------------------------

23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-27-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo</u>
--	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>Wetzel Bros</u>	ADDRESS <u>2201 S Grand</u>	25. DATE RECD. BY LOCAL REG. <u>9-26-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
--	--------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

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 Elton R. Penick

Licensed Embalmer No. 4283

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.