

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9381

-61-039017
STATE FILE NUMBER

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in lb		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. ANTHONY HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3000 MISSOURI AVE.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>(AWEEN) PEGGY NABER</u>				4. DATE OF DEATH Month Day Year <u>OCT 10 1961</u>					
5. SEX <u>FEMALE</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>OCT 23 1914</u>		9. AGE (last birthday) <u>46</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED BOOKKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>				13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>BERNARD W NABER</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>						17. INFORMANT Address <u>BERNARD W. NABER 3000 MISSOURI</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>Rupture of Aneurysm branch of right carotid artery</u> DUE TO (b) <u>possible injury to back</u> DUE TO (c) <u>452X4</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
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 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.) <u>Fell down basement steps about 1 1/2 months prior to death</u>					
20c. TIME OF INJURY Hour a.m. <u>abt.</u> Month, Day, Year <u>9 1 61</u>		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>home</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis, Missouri</u>		COUNTY STATE	
21. I attended the deceased from <u>April 10 - 1956</u> to <u>Oct. 10 - 61</u> and last saw her/him alive on <u>Oct 10 - 1961</u> Death occurred at <u>5 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Frank C. Louch Sr. M.D.</u>				22b. ADDRESS <u>2767 Gravois St. St. Louis 8 Mo</u>		22c. DATE SIGNED <u>10-10-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>OCT. 13. 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>JEFFERSON BARRACKS MO.</u>			
24. FUNERAL DIRECTOR <u>Thomas Kute 2906 Gravois</u>				25. DATE RECD. BY LOCAL REG. <u>OCT 11 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith. M.D.</u>			

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

Eleana Province

Licensed Embalmer No. 3403

P. O. Address 7906 Gravo

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.