

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042840

DEPARTMENT OF PUBLIC HEALTH AND WELFARE  
 Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11392** STATE FILE NUMBER

AMENDED  
**FILED DEC 12 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony's Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>5805 S. Broadway</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Hallie</b> Middle <b>G.</b> Last <b>Rothley</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20, 1899</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months <b>3</b> Days <b>15</b> Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Indiana</b>		
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Sollie Simpson</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Sharp</b>		
14. NAME OF HUSBAND OR WIFE <b>Arthur (Deceased)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT Address <b>Edward Stevens 740 Bayless</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>			<b>5 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<b>Myocardial infarction (old)</b>	<b>2 mo</b>
	DUE TO (c)	<b>Bronchitis 420.1</b>	<b>2 mo</b>

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	
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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.)		
20c. TIME OF INJURY Hour 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
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21. I attended the deceased from **6-14-50** to **12-5-61** and last saw her/him alive on **12-5-61**  
 Death occurred at **6:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Edith Withler MD</b> (Degree or title)	22b. ADDRESS <b>5600 S Coington</b>	22c. DATE SIGNED <b>12-6-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Dec. 8, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>
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24. FUNERAL DIRECTOR <b>Schumacher's 3013 Meramec St.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>DEC 7 1961</b>	26. REGISTRAR'S SIGNATURE <b>Edith Withler M.D.</b>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

OFFICE OF THE STATE BOARD OF HEALTH

DR. NESTER  
5600 S. COMPTON  
FL. 1-3383

**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 Jack Haepp  
Licensed Embalmer No. 4746

P. O. Address \_\_\_\_\_

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.