SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

~~61-042909~~

MENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10502 STATE FILE NUMBER 42909

FILED NOV 28 1961

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b 8 days

c. CITY OR TOWN Belridge (SL 34) — Inside Limits Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 4327 Rickey Dr. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First STELLA Middle JOHANNA Last SMITH

4. DATE OF DEATH Month Nov. Day 12, Year 1961

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 2-22-1885

9. AGE (last birthday) 76 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary

10b. KIND OF BUSINESS OR INDUSTRY Childrens Social Work

11. BIRTHPLACE (City and state or country) St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Frederick Borggraefe

13b. MOTHER'S MAIDEN NAME Marie Koch

14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service

16. SOCIAL SECURITY NO.

17. INFORMANT Fred Borggraefe, Address 4327 Rickey Dr. St. Louis 34, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bilateral pneumonitis with — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) myocardial ischemia — 2 mo.

DUE TO (c) 492x

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 9-20-61, to 11-12-61 and last saw her/him alive on 11-11-61.
Death occurred at 4:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Carlo Rao M.D. M.D.

22b. ADDRESS 5074 N. Union

22c. DATE SIGNED 11-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 11-14-61

23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

24. FUNERAL DIRECTOR ADDRESS The Florissant Mortuary, Florissant, Mo.

25. DATE RECD. BY LOCAL REG. NOV 13 1961

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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_____ Signed Gene S Hutchins

Signature of Student Embalmer

Licensed Embalmer No. 4966

P. O. Address Florissant, 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.