

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046090
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12206**

AMENDED

FILED JAN 5 1962

1. PLACE OF DEATH a. COUNTY <u>MISSOURI</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MISSOURI</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Length of stay in 1b <u>LIFE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR LITTLE-SISTERS-OF-THE-POOR INSTITUTION <u>3225-NO. FLORISSANT-AV.</u>		d. STREET ADDRESS (If outside, give location) <u>ST. FORMERLY: 1434-MALLINCKRODT</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY-CHRISTINA-BODE</u>			4. DATE OF DEATH Month Day Year <u>DEC. 26TH 1961</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1873</u>	9. AGE (last birthday) <u>88 YRS.</u>	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) <u>PAPER-FLOWER-MFG.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MISSOURI-FLOWER & FEATHER-CO.</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS-MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN-BODE</u>		13b. MOTHER'S MAIDEN NAME <u>GERTRUDE-LUECKE</u>		14. NAME OF HUSBAND OR WIFE <u>NEVER-MARRIED</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 (<u>HER-SELF</u>) <u>PRE-ARRANGED-FUNERAL-1434-MALLINCKRODT.</u>	
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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>Arterio-sclerotic-heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>???</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>420.0</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>		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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>None</u>	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 <u>Dec 20, 1961</u> to <u>Dec 26, 1961</u> and last saw her alive on <u>Dec 23, 1961</u> Death occurred at <u>17:30 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 & title) <u>Bernard A. Flohe MD</u>	22b. ADDRESS <u>2435 N. Grand Blvd</u>	22c. DATE SIGNED <u>12-27-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-29-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>
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24. FUNERAL DIRECTOR <u>Brookland Und. Co. 1827-HOGAN-ST.</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 28 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loed Smith M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Elmer R. Sadwell

Licensed Embalmer No. 4077
P. O. Address St Louis

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.