SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED JAN 5 1962

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12205 — 61-046807 STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Lukes Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN: University City
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1006 Sutter Ave.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: ANNA Middle: Rucken Last: brod

4. DATE OF DEATH: Month: 12 Day: 19 Year: 61

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 12-2-1901

9. AGE (last birthday): 60

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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Missouri

12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: (Unknown) Stephmeier

13b. MOTHER'S MAIDEN NAME: Katherine (Unknown)

14. NAME OF HUSBAND OR WIFE: --

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.: none

17. INFORMANT: St. Lukes Hospital Records
Address:

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): Diffuse bilateral bronchopneumonia
INTERVAL BETWEEN ONSET AND DEATH: one month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Rheumatoid arthritis.

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 8/12/60 to 12/19/61 and last saw her/him alive on 12/19/61

Death occurred at 4:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): George A. Kolbey, M.D.

22b. ADDRESS: St. Luke's Hosp.

22c. DATE SIGNED: 12/20/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE: 12-30-61

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

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

24. FUNERAL DIRECTOR: Rowland-Aker Mortuary Service
ADDRESS: 4104 Manchester Ave.

25. DATE RECD. BY LOCAL REG.: DEC 28 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_____
Signature of Student Embalmer

Licensed Embalmer No._____

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.