

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24294

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5556

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, write RURAL and give town) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>5 days</u>		c. CITY OR TOWN <u>St. Louis</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>5472 Thrush Ave.</u> <u>2675</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Christine</u> b. (Middle) <u>K.</u> c. (Last) <u>Rohne</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 25 1955</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		
8. DATE OF BIRTH <u>Dec. 11 1882</u>		9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Rolla Mo</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Joseph Berger</u>		13b. MOTHER'S MAIDEN NAME <u>Annie O. Schurr</u>		
14. NAME OF HUSBAND OR WIFE <u>Harry W. Rhone</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		
17. INFORMANT'S SIGNATURE OR NAME <u>Harry W. Rhone</u>		ADDRESS <u>5472 Thrush Ave.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, Hypertension</u> DUE TO (c) <u>Cardiovascular failure</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Several years</u> <u>about 1 mo.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>331X</u>		
22. I hereby certify that I attended the deceased from <u>June 21, 1955</u> to <u>June 25, 1955</u> , that I last saw the deceased alive on <u>June 25, 1955</u> , and that death occurred at <u>1:15 p. m.</u> , from the causes and on the date stated above.						
23a. SIGNATURE <u>Arnold Klein MD</u>		(Degree or title) <u>MD</u>		23b. ADDRESS <u>2632 So Kingshighway</u>		
23c. DATE SIGNED <u>6/27/55</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>6/28/55</u>		
24c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>				
DATE REC'D BY LOCAL REG. <u>JUN 27 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Drehmann-Harral</u> ADDRESS <u>1905 Union Blvd.</u>		

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

Dr. Arnold Klein,
2632 S. Kingshighway

11 - 3.30

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: *Warren A. Carver*

Licensed Embalmer No. *35*

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.