

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026636

FILED VS JUL 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **8 6371** STATE FILE NUMBER

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | c. CITY OR TOWN ST. LOUIS | |
| Length of stay in 1b | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION INCARNATE WORD HOSP. | | d. STREET ADDRESS (If outside, give location) 4119 QUINCY | |
| 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 MARY MAGDALENA FORRESTER | | | 4. DATE OF DEATH Month Day Year JULY 4 1959 | | | |
|---|--|--|--|--|--|--|

| | | | | | | |
|-------------------------|----------------------------------|---|--|-------------------------------------|--------------------------------|------------------------------|
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH APR. 7 1883 | 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) HOUSE WORK | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | 11. BIRTHPLACE (City and state or country) MISSOURI | 12. CITIZEN OF WHAT COUNTRY U - S - A |
|--|---|---|---|

| | | |
|--|---|--|
| 13a. FATHER'S NAME AUGUST RICK | 13b. MOTHER'S MAIDEN NAME AGNES FRICKER | 14. NAME OF HUSBAND OR WIFE CULLEN R FORRESTER |
|--|---|--|

| | | |
|---|--|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT Address MARY KLEIN 3679 MONTANA |
|---|--|---|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease Arterio-sclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 6 months |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 420.0 | | |

| | | |
|---|--|---|
| 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 |
|---|--|---|

| | | |
|---|---|--|
| 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 a.m. p.m. 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 Jan 1959 to July 4 1959 | COUNTY St. Louis | STATE MO |
|---|--|--|--|----------------------------|--------------------|

| | |
|---|--|
| 21. I attended the deceased from Jan 1959 to July 4 1959 and last saw her/him alive on July 3, 1959 Death occurred at 7:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | |
|---|--|

| | | | |
|--|-----------------|-----------------------------------|-----------------------------------|
| 22a. SIGNATURE Ralph Berg M.D. | (Degree, title) | 22b. ADDRESS 3203 Grand | 22c. DATE SIGNED 7/6/59 |
|--|-----------------|-----------------------------------|-----------------------------------|

| | | | |
|---|---------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE JULY 7 1959 | 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM. | 23d. LOCATION (City, town, or county) ST. LOUIS CO MO |
|---|---------------------------------|--|---|

| | | |
|--|--|---|
| 24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravoie | 25. DATE RECD. BY LOCAL REG. JUL 6 '59 | 26. REGISTRAR'S SIGNATURE Earl Smith M.D. |
|--|--|---|

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Jc

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.