

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-042412**

**FILED VS DEC 7 1959**

**211053**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Ann's Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5301 Page Blvd.</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia Judge Ring</b>				4. DATE OF DEATH Month Day Year <b>November 29th., 1959</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8/7/1869</b>	9. AGE (last birthday) <b>90</b>	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) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Arthur J. Judge</b>			13b. MOTHER'S MAIDEN NAME <b>Catherine Clarke</b>		14. NAME OF HUSBAND OR WIFE <b>Paul F. Ring</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Miss Kathleen Clarke Ring, 7762 Wise Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>						10 yrs.	
DUE TO (c) <b>331X</b>							
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		COUNTY	STATE
21. I attended the deceased from <b>November 11, 1959</b> to <b>November 29</b> and last saw <sup>him</sup> alive on <b>November 29</b> Death occurred at <b>Reister</b> <b>6:04 pm.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Robert M. Louch, M.D.</b>			22b. ADDRESS <b>52 Maryland Plaza</b>			22c. DATE SIGNED <b>30 Nov. 59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>12/1/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>			(State)
24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b>		ADDRESS <b>3840 Lindell Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 30 1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

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 Francis McMillon

Licensed Embalmer No. 3562

P. O. Address 3840 Lu

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.