

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

**-60-003270**

**FILED VS FEB 1 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 521** STATE FILE NUMBER

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>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>D.O.A.</b>	c. CITY OR TOWN <b>Northwoods</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>DePaul Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4714 Oakridge Blvd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>STELLA</b> Middle <b>CRIPPS</b> Last			4. DATE OF DEATH Month <b>Jan.</b> Day <b>14,</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/05</b>	9. AGE (last birthday) <b>54</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fuse Mfg. Co.</b>	11. BIRTHPLACE (City and state or country) <b>Licking, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Joseph Sliger</b>		13b. MOTHER'S MAIDEN NAME <b>Belle Bohonman</b>		14. NAME OF HUSBAND OR WIFE <b>George E. Cripps</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>497-03-5242</b>	17. INFORMANT Address <b>George E. Cripps 4714 Oakridge Blvd</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>unknown natural causes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden death</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

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	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>1/14/60</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>2/4/58</b> to <b>1/14/60</b> and last saw her <b>1/11/60</b> alive on <b>1/11/60</b> Death occurred at <b>4 15 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Robert A. Bauer MD</b> (Degree or title)	22b. ADDRESS <b>3731 Goodfellow</b>	22c. DATE SIGNED <b>1-14-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1/18/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
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24. FUNERAL DIRECTOR <b>Callen Kelly</b> ADDRESS <b>7267 Natural Bridge</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 15 1960</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James A. Lamm

Licensed Embalmer No. 414

P. O. Address St. Louis

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.