

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004005

FILED VS JAN 15 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2129 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>247 westminster</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5247 Westminster Pl.</u>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>W.</u> Last <u>Russe</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Indianapolis, Ind.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>William Russe</u>		13b. MOTHER'S MAIDEN NAME <u>Clara Northway</u>	
14. NAME OF HUSBAND OR WIFE <u>Elizabeth</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes No</u>		16. SOCIAL SECURITY NO. <u>488-01-0861</u>	
17. INFORMANT <u>Elizabeth Russe</u>		Address <u>5247 Westminster</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic cor pulmonale</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>to yrs</u>
DUE TO (b) <u>Bronchial asthma</u>		
DUE TO (c) <u>241x</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Multiple Cerebral Thromboses</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 Nov 1958 to Jan 4 1960 and last saw him alive on Jan 4, 1960
Death occurred at 8:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Kenneth Price M.D.</u>		22b. ADDRESS <u>57 Maryland Plaza</u>		22c. DATE SIGNED <u>1-5-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-6-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery St. Louis, Missouri</u>		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <u>C.R. Lupton & Sons, St. Louis, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 5 1960</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

VS APR 8 1963

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo.

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.