

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-004445

FILED VS FEB 15 1960 317

Registration District No. 547 Primary Registration District No. 401 Registrar's No.

STATE FILE NUMBER

DOED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>ST LOUIS</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHMOND HEIGHTS</u>		a. STATE <u>Mo</u>		b. COUNTY <u>St Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST MARY'S HOSPITAL</u>		Length of stay in 1b <u>5 HRS</u>		c. CITY OR TOWN <u>WEBSTER GROVES</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>102 CHESTNUT ST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>BESSIE</u>		Middle <u>T</u>		Last <u>CLARK</u>		Month <u>2</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-10-'96</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR	IF UNDER 24 HR	
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>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>EUROPE ?</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN TUMA</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>-</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Robert A Clark 104 Chestnut St N.E. Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Diabetes melitus, Aoidonia septicemia</u>						<u>2 w 1 d</u>	
DUE TO (b) <u>Ulceration gangrene of foot</u>						<u>u 1 d</u>	
DUE TO (c) <u>Arterio sclerosis</u>						<u>u 1 d</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Broncho pneumonia, Pyelonephritis</u>						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 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 How 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 <u>2/6/60</u> to <u>2/6/60</u> and last saw her alive on <u>2/6/60</u> Death occurred at <u>3</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Carl L Brand MD</u>				22b. ADDRESS <u>Webster Groves Mo</u>		22c. DATE SIGNED <u>2/8/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-8-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>		23d. LOCATION (City, town, or county) <u>KIRKWOOD 22 Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>MITTELBERG</u>		ADDRESS <u>WEBSTER GROVES MO</u>		25. DATE RECD. BY LOCAL REG. <u>2-8-60</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy MD</u>		

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 Robert M. Murray

Licensed Embalmer No. 3749

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.