

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012817

FILED VS MAR 24 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's 2 2788 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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO</u>		c. CITY OR TOWN <u>St. Louis</u>	
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 <u>ST. LOUIS CITY HOSP. #1</u>		d. STREET ADDRESS (If outside, give location) <u>854 Elias Ave</u>	
Inside Limits Yes <input 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 <u>HENRY</u> Middle <u>W</u> Last <u>KERLS</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24/00</u>	9. AGE (last birthday) <u>89</u>	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) <u>retired blacksmith</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>William Kerls</u>		13b. MOTHER'S MAIDEN NAME <u>not known</u>	
14. NAME OF HUSBAND OR WIFE <u>Betha Kerls</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>49116-7274</u>	17. INFORMANT <u>Elmer Benhardt, 1122 Howell</u>	Address
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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 <u>1 WEEK</u>
IMMEDIATE CAUSE (a) <u>BILATERAL BRONCHOPNEUMONIA</u>		
DOE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		
DOE TO (c) <u>491x</u>		
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 2/26/60 to 3/8/60 and last saw her/him alive on 3/8/60  
Death occurred at 6:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Edward M. W. [Signature]</u> (Physician's title) <u>M.D.</u>	22b. ADDRESS <u>1515 LAFAYETTE AVE</u>	22c. DATE SIGNED <u>3/8/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>3/11/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>
23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo</u>		(State)

24. FUNERAL DIRECTOR <u>DIETRICH FUNERAL HOME, 8319 Hallsferry</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 10 1960</u>	26. REGISTRAR'S SIGNATURE <u>Roal Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**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

*J. W. Rinkley*

Licensed Embalmer No. 7653

P. O. Address *St. Louis*

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.