

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013703

FILED VS MAR 30 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 883 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lemay</u>		Length of stay in lb <u>18 Months</u>		c. CITY OR TOWN <u>Rock Hill</u>		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>Mt. St. Rose Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9837 Oakhaven</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L.</u> Last <u>BOTT</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Female</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>6-7-1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>White Hall, Penn.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Jacob Johns</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Rieder</u>			14. NAME OF HUSBAND OR WIFE <u>Late Stephan Bott</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 <u>Florence Bott 9837 Oakhaven</u> Address			
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>Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized arteriosclerosis</u>							<u>yr?</u>
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	
19. WAS AUTOPSY PERFORMED? YES <input 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 <u> </u> a.m. <u> </u> p.m. <u> </u>	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>Feb 6</u> to <u>March 12</u> and last saw her <u>March 11</u> alive on <u> </u>				Death occurred at <u>8:20 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>William D. Turner M.D.</u>			22b. ADDRESS <u>4401 Hampton</u>			22c. DATE SIGNED <u>3-13-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Mar. 15, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S.Kingshighway Blvd.</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3-14-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

DOCUMENT

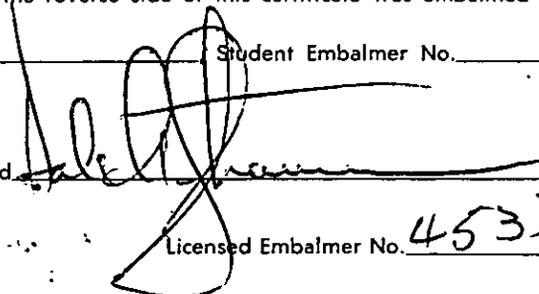
MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 4533

P. O. Address _____

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.