

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016537
STATE FILE NUMBER

FILED VS APR 26 1960

Registration District No. 316 Primary Registration District No. — Registrar's No. 153

1. PLACE OF DEATH a. COUNTY ST. FRANCOIS				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FARMINGTON-RURAL		Length of stay in 1b 1 WK.		c. CITY OR TOWN OVERLAND		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION THOMAS DELL HOME			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2728 PASTEUR		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First STELLA Middle MAY Last CALIF				4. DATE OF DEATH Month APRIL Day 19 Year 1960									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH NOV. 6 1886		9. AGE (last birthday) 73		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) HOUSE WORK			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME			11. BIRTHPLACE (City and state or country) ILLINOIS			12. CITIZEN OF WHAT COUNTRY U S A				
13a. FATHER'S NAME SAMUEL REXROAT				13b. MOTHER'S MAIDEN NAME UNKNOW				14. NAME OF HUSBAND OR WIFE DECEASED					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS RAYMOND McCARVER ST. LOUIS MO							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MEDULLARY PARALYSIS										INTERVAL BETWEEN ONSET AND DEATH 2 da			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) THROMBOTIC ENCEPHALOMALACIA & CEREBRAL HEMORRHAGE										2 wk			
DUE TO (c) ARTERIOSCLEROSIS										Unknown			
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 4-18-60 , to 4-19-60 and last saw her alive on 4-18-60 Death occurred at 9:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE M. Kulae DO. (Degree or title)						22b. ADDRESS Farmington Mo.			22c. DATE SIGNED 4-20-60				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APRIL 22 1960		23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK			23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MISSOURI						
24. FUNERAL DIRECTOR CLARK FUNERAL HOME ST. LOUIS MO				25. DATE RECD. BY LOCAL REG. Apr. 20, 1960		26. REGISTRAR'S SIGNATURE Ether Redliff							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

PR 2 6 1966

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. 408

P. O. Address Farmington

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.