

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016883

FILED VS APR 29 1960

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			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 St. Louis		Length of stay in 1b	c. CITY OR TOWN Webster Groves		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 826 Grelly		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle Austin Last Gundelfinger			4. DATE OF DEATH Month April Day 10 Year 1960			
5. SEX Female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1870	9. AGE (last birthday) 89	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY housewife	11. BIRTHPLACE (City and state or country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Joseph B. Austin		13b. MOTHER'S MAIDEN NAME Josephine C. Carlisle		14. NAME OF HUSBAND OR WIFE Ellsworth D. Gundelfinger		
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 Mr. Ellsworth D. Gundelfinger 826 Grelly			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 15 hours	
DUE TO (b) Arteriosclerosis - generalized					15 years	
DUE TO (c) 331X						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hepatic insufficiency					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 Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____						
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 June 7, 1955 to April 10, 1960 and last saw her April 10, 1960 alive on April 10, 1960 Death occurred at 9:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE Henry Rouseff (Degree or title) M.D.			22b. ADDRESS 7165 Delmar Blv'd.		22c. DATE SIGNED 4/11/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 13, 1960	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Missouri.		
24. FUNERAL DIRECTOR C.R. Lupton and Sons 7233 Delmar Blv'd.		25. DATE RECD. BY LOCAL REG. APR 11 1960	26. REGISTRAR'S SIGNATURE Roald Smith M.D. <i>m & c</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Mrs. Mattie Sandberg

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 *Carene H. Furr*

Licensed Embalmer No. 4011
P. O. Address *H. Furr*

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.