

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024284

FILED VS JUL 12 1960

318 Primary Registration District No. 1003 Registrar's No. 6456

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Iowa b. COUNTY Lee			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 40 days		c. CITY OR TOWN Keokuk		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis - Little Rock Hospitals, Inc.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 908 Franklin Str.	
3. NAME OF DECEASED (Type or print) First Harry Middle Bruce Last Andrew				4. DATE OF DEATH Month June Day 22, Year 1960			
5. SEX Male	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 12-1-1901	9. AGE (last birthday) 58	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) Ass't. Personnel Director		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and state or country) Brazil, Indiana		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James F. Andrew			13b. MOTHER'S MAIDEN NAME Anna Kriebler			14. NAME OF HUSBAND OR WIFE Mabel	
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. 717-03-3254		17. INFORMANT Address James F. Andrew 2416 McKinley Keokuk, Iowa		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS ACUTE POST OP. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) POST OP. DEMISENCE GASTROTOMY DUE TO (c) OPERATION FOR GASTRIC ULCER						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 10 DAYS 20 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 540.0						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 s.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 May 14, 1960 to June 22, 1960 and last saw her alive on June 22, 1960 Death occurred at 10:50 P. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Newell Saffron M.D.			22b. ADDRESS 3720 WASHINGTON BLVD			22c. DATE SIGNED 23 JUNE 60	
23a. BURIAL, CREMATION REMOVAL (Specify) Removal		23b. DATE 6-23-60		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens		23d. LOCATION (City, town, or county) Keokuk, Iowa	
24. FUNERAL DIRECTOR Schmidt Memorial Hall - Keokuk, Iowa			25. DATE RECD. BY LOCAL REG. JUN 24 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D. m JB		

(Licensed Embalmer's Statement on Reverse Side)

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 Stanley H. Deeds

Licensed Embalmer No. 4193

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.