URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED 15 AUG 1 0 1960

-60-028251

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Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7083 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Our Lady of Perpetual ~~Help Nursing Home~~
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: Creve Couer
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): #1 Sherwyn Lane
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First MARY Middle R. Last DeVILLE
4. DATE OF DEATH: Month July Day 14 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 5-28-1877
9. AGE (last birthday): 83
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): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Youngstown, Ohio
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: John Santry
13b. MOTHER'S MAIDEN NAME: Alice McMullen
14. NAME OF HUSBAND OR WIFE: Late Augustus B. DeVille
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Marie C. Krack #1 Sherwyn Lane

MEDICAL CERTIFICATION

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
IMMEDIATE CAUSE (a)	CONGESTIVE HEART FAILURE	1wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	10 yrs
DUE TO (c)	~~Are~~ CEREBRAL ARTERIOSCLEROSIS	?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 420.0

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Jan. 1960, to July 1960 and last saw her/him alive on 7/13/1960
Death occurred at 5:00 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature], MD (Degree or title)
22b. ADDRESS: 4145 So Broad
22c. DATE SIGNED: 7/14/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal (Rec)
23b. DATE: July 15, 1960
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): Cleveland, Ohio

24. FUNERAL DIRECTOR ADDRESS: Kriegshauser 9450 Olive St. Road
25. DATE RECD. BY LOCAL REG.: JUL 14 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed R. W. Storsand

Signature of Student Embalmer

Licensed Embalmer No. 4 C 07

P. O. Address St. Louis

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