

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028764

FILED VS JUL 19 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **657E** STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS</b>		Length of stay in 1b <b>5 DAYS</b>	c. CITY OR TOWN <b>MEHLVILLE</b> <b>4850</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST ANTHONY HOSP.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rt 8 - Box 1165</b>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>CAROLINE P SAUL</b>			4. DATE OF DEATH Month Day Year <b>JUNE - 24 - 1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB-15-1893</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <b>4 9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (City and state or country) <b>ROCK CO, WISCONSIN</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>FREDRICK WERNER</b>		13b. MOTHER'S MAIDEN NAME <b>PAULINE EIGHSTAET</b>		14. NAME OF HUSBAND OR WIFE <b>LEONARD P. SAUL</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>LEONARD P. SAUL</b> Address <b>Rt 8 - Box 1165 MEHLVILLE MO</b>		

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) <b>cerebral thrombosis</b>		<b>5 days</b>
DUE TO (b) <b>cerebral arteriosclerosis</b>		
DUE TO (c) <b>Cerebral arteriosclerosis</b>		<b>4</b>
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.) <b>6-19-60</b>	20f. CITY, TOWN, OR LOCATION <b>6-24-60</b>	COUNTY <b>6-24-60</b>	STATE
21. I attended the deceased from <b>6-19-60</b> to <b>6-24-60</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>6-24-60</b> Death occurred at <b>7 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>John J. Ankley</b> (Degree or title)	22b. ADDRESS <b>5253 Chippewa</b>	22c. DATE SIGNED <b>6-28-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JUNE-28-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW ST MARCUS PGM</b>
24. FUNERAL DIRECTOR <b>FAY FUNERAL HOME</b>	ADDRESS <b>MEHLVILLE MO</b>	25. DATE RECD. BY LOCAL REG. <b>JUN 28 1960</b>
		26. REGISTRAR'S SIGNATURE <b>Leon Smith, M.D.</b>

(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 Gustav W. Dietz

Licensed Embalmer No. 4329

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.