

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-029108**

FILED VS. JUL 22 1960 317

547

Registrar's No. 2080

STATE FILE NUMBER

DED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Hts.</b> Length of stay in 1b <b>5 Weeks</b> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Westphalia</b> c. CITY OR TOWN <b>Westphalia</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>Westphalia, Mo.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CLARA</b> Middle <b>C.</b> Last <b>HOER</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>12</b> Year <b>1960</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8-10-1880</b>	<b>9. AGE (last birthday)</b> <b>79</b>	<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>	<b>IF UNDER 24 HR</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Westphalia, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>Martin Bode</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Late Anton C. Hoer</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Late Anton C. Hoer</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Mary Schriewer 3871 Humphrey St.</b>			Address
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>granuloma generalized</b> DUE TO (b) <b>Paraselytic</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis - chr brain syndrome</b>						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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in PART I or PART II of item 18.) _____				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____			<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____		<b>STATE</b> _____	
<b>21. I attended the deceased from</b> <b>6-8-60</b> to <b>7-12-60</b> and last saw her alive on <b>7-12-60</b> Death occurred at <b>10:00 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>Committer MD</b>			<b>22b. ADDRESS</b> <b>4161 Russell Blvd.</b>			<b>22c. DATE SIGNED</b> <b>7/12/60</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal (Mtr)</b>		<b>23b. DATE</b> <b>July 13, 1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Joseph Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Westphalia, Mo.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>7-12-60</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>J. B. Murphy M.D.</b>		

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 William B White

Licensed Embalmer No. 4091

P. O. Address 2200 1/2 St

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.