

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031737

FILED VS SEP 7 1960

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 170

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in 1b 2 Weeks	c. CITY OR TOWN St. Charles 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. Joseph Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1073 Madison Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Zaida Middle M. Last White			4. DATE OF DEATH Month August Day 28 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1884	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-keeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Cottleville, Mo.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Julius Hirsch		13b. MOTHER'S MAIDEN NAME Mary Bauer		14. NAME OF HUSBAND OR WIFE Joseph H. White		
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 Mrs. A. A. Rothe, St. Charles, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 12 days
DUE TO (b) Arteriosclerosis		?
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Thrombosis		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 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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from **July 3 1960** to **Aug. 28, 1960** and last saw her ^{her} alive on **Aug. 27, 1960**
Death occurred at **54 A M** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. M. Baue MD</i>		(Degree or title)	22b. ADDRESS <i>St. Charles, Mo</i>		22c. DATE SIGNED <i>Aug. 29, 1960</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/30/1960	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town, or county) (State) St. Charles, Mo.	
24. FUNERAL DIRECTOR Arthur C. Baue, St. Charles, Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. Aug 30 - 60	26. REGISTRAR'S SIGNATURE <i>Marcella Wilson</i>	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

0961 9 100
OCT 5 1980

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

David C. Rowe

Licensed Embalmer No. 5060

P. O. Address St. Charles

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.