URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1960 318

-60-032084
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 7931

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b: 1 Week
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Mo.Baptist Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Dent
c. CITY OR TOWN: Salem
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 305 West C.Ave
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Anna Middle Roth Last Dean

4. DATE OF DEATH: Month August Day 8 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1/20/1891
9. AGE (last birthday): 69
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): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): St.Louis,Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Gotleib Roth
13b. MOTHER'S MAIDEN NAME: Magdelena Legler
14. NAME OF HUSBAND OR WIFE: Wilson E.Dean

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: Mr Wilson E.Dean Address: 305 West C.Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis of abdomen
DUE TO (b): Primary in pancreas
DUE TO (c): 157X
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 6 month

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. ☐ 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 May 30, 1960 to Aug 8, 60 and last saw her/him alive on Aug 8, 1960
Death occurred at 12 P.M. Aug 8, 1960 on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE: Robert Thomasson (Degree or title) M.D.
22b. ADDRESS: 100 N Euclid
22c. DATE SIGNED: 8-9-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 8/11/60
23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
23d. LOCATION (City, town, or county) (State): St.Louis Co,Missouri

24. FUNERAL DIRECTOR: Alexander & Sons ADDRESS: 6175 Delmar Blv
25. DATE RECD. BY LOCAL REG.: AUG 11 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DOCUMENT

BY AFFIDAVIT OF

Dr.Robert Thomasson
100 No.Euclid Ave
~~XXXXXXXX~~
Fo.7-4657
4 to 5 P.M.

SEP 9 1960

AUG 23 1962

SEP 5 1961

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 J. Allen Davis

Licensed Embalmer No. 405

P. O. Address St. L.
Aug 1960

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.