

FILED VS. SEP 14 1960

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8905

STATE FILE NUMBER

Primary Registration District No. Registrar's No.

| | | | | | |
|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MISSOURI</i> | | Length of stay in 1b | c. CITY OR TOWN <i>ST. LOUIS</i> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <i>BARNES HOSPITAL</i> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <i>3412 E EADS</i> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>CHARLES B. ULRICH</i> | | | 4. DATE OF DEATH Month Day Year <i>SEPTEMBER 6 1960</i> | | |
| 5. SEX <i>MALE</i> | 6. COLOR OR RACE <i>WHITE</i> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>JULY 29 1903</i> | 9. AGE (last birthday) <i>57</i> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SHOE WORKER</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>VALLEY SHOE CO</i> | 11. BIRTHPLACE (City and state or country) <i>ST. LOUIS Mo</i> | 12. CITIZEN OF WHAT COUNTRY <i>U-S-A.</i> | |
| 13a. FATHER'S NAME <i>WILLIAM ULRICH</i> | | 13b. MOTHER'S MAIDEN NAME <i>JULIA DOERR</i> | | 14. NAME OF HUSBAND OR WIFE <i>UNKNOWN</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>492-01-7251</i> | 17. INFORMANT Address <i>BETTY VAIL 550 N. 13th EAST ST. LOUIS, ILL</i> | | |
| 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) <i>EROSION OF CAROTID ARTERY</i> | | | | | <i>2 MINUTES</i> |
| DUE TO (b) <i>CARCINOMA OF BASE OF TONGUE</i> | | | | | <i>2 YEARS</i> |
| DUE TO (c) <i>141-D</i> | | | | | |
| 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 type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <i>JAN. 3, 1960</i> to <i>SEPT. 6, 1960</i> and last saw ^{her} him alive on <i>SEPT. 6, 1960</i> Death occurred at <i>3:15 P.M.</i> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Dr Bradley</i> | | | 22b. ADDRESS <i>BARNES HOSPITAL</i> | | 22c. DATE SIGNED <i>9/7/60</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i> | 23b. DATE <i>SEPT 10 1960</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>ST. PAUL CHURCHYARD</i> | | 23d. LOCATION (City, town, or county) <i>ST. LOUIS Mo</i> | |
| 24. FUNERAL DIRECTOR <i>Thomas Hater 2906 Levee</i> | | 25. DATE RECD. BY LOCAL REG. <i>SEP 9 1960</i> | 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JANUARY 1972

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 James E. White

Licensed Embalmer No. 43477

P. O. Address 2906

Note: The above ~~MUST~~ **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.