

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040511

FILED VS OCT 24 1960

317 Primary Registration District No. 54/ Registrar's No. 2912

STATE FILE NUMBER

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| 1. PLACE OF DEATH<br>a. COUNTY <b>ST Louis</b>                                       |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO</b> b. COUNTY <b>ST Louis</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>CLAYTON</b>          |  | c. CITY OR TOWN <b>CHESTERFIELD</b>   |  |
| Length of stay in 1b<br><b>3 DAYS</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br><b>COUNTY Hosp</b>            |  | d. STREET ADDRESS <b>R#1 EATHERTON RD</b>   |  |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |

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| 3. NAME OF DECEASED<br>(Type or print) <b>Lanna JANE Sutton</b> |  |  | 4. DATE OF DEATH<br>Month <b>10</b> Day <b>4</b> Year <b>1960</b> |  |  |
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| 5. SEX<br><b>FEMALE</b> | 6. COLOR OR RACE<br><b>WHITE</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-17-1893</b> | 9. AGE (last birthday)<br><b>87</b> | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HR<br>Hours Min. |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWORK</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b> | 11. BIRTHPLACE (City and state or country)<br><b>ST Louis Co, MO</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
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| 13a. FATHER'S NAME<br><b>WM. RICHARD</b> | 13b. MOTHER'S MAIDEN NAME<br><b>LUCINDY LUDWIG</b> | 14. NAME OF HUSBAND OR WIFE<br><b>WM. SUTTON</b> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br><b>FRED BROEMMELSIEN</b> | Address<br><b>Chesterfield Mo.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b> |
| IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>  |  |   |
| DUE TO (b) <b>Cerebral arteriosclerosis</b>   |  |   |
| DUE TO (c) <b>Generalized arteriosclerosis</b>  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a))<br><b>Arterial nephrosclerosis</b>          |  |   |
| PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |

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| 19. WAS AUTOPSY PERFORMED?<br>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.) |
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| 20c. TIME OF INJURY<br>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<br><b>COUNTY STATE</b> |
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| 21. I attended the deceased from <b>10-1-1960</b> to <b>10-4-1960</b> last saw her/him alive on <b>10-4-1960</b><br>Death occurred at <b>8:40 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |
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| 21a. SIGNATURE<br><b>Albert P. Howe M.D.</b> (Degree or title) | 21b. ADDRESS<br><b>601 S. Brentwood, Clayton</b> | 21c. DATE SIGNED<br><b>10/4/60</b> |
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| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 22b. DATE<br><b>10-7-60</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Antioch Baptist</b> | 22d. LOCATION (City, town, or county)<br><b>Monarch Mo.</b> |
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| 24. FUNERAL DIRECTOR<br><b>Schradel Funeral Home</b> | ADDRESS<br><b>Ballwin Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>10-5-60</b> | 26. REGISTRAR'S SIGNATURE<br><b>John C. Muesel</b> |
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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 Harry F. Schrader

Licensed Embalmer No. 2091

P. O. Address Ballwin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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.