RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961 318 1003 12404 -60-047880

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER

IDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Saint Louis — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 2162 Farrar — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY

c. CITY OR TOWN: Saint Louis — Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 2162 Farrar — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First EVIE — Middle MAY — Last RUE

4. DATE OF DEATH: Month December — Day 21, — Year 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 7/13/94

9. AGE (last birthday): 66 — 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): Housework

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (City and state or country): Hannibal, Missouri

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Sherman Rue

13b. MOTHER'S MAIDEN NAME: Rosie Slayton

14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Clora Rue, Address: 2162 Farrar

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 Day

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Coronary Arteriosclerosis — unknown

DUE TO (c): 420.1

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 12 Dec 1960, to 21 Dec 1960 and last saw her/him alive on 20 Dec 1960

Death occurred at 1 P.m. on the date stated above and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M. A. Mueller

22b. ADDRESS: M. A. Mueller, M. D. 3524 Franklin Ave. St. Louis 6, Mo.

22c. DATE SIGNED: DEC 23 1960

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 12/27/60

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Co., Missouri

24. FUNERAL DIRECTOR — ADDRESS: Charles J. Gates, 4107 Finney

25. DATE RECD. BY LOCAL REG.: DEC 27 1960

26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

MEDICAL CERTIFICATION

DOCUMENT

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Guyton Swa

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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