MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-010399

STATE FILE NUMBER

D APR 7 1961

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2965

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. — Length of stay in 1b	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1 — Inside Limits Yes ☐ No ☐	d. STREET ADDRESS (If outside, give location) 4349 Olive — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CONCORDIA	L.	ASHE	MARCH	27,	1961

5. SEX	6. COLOR OR RACE	7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
Female	White		May 21, 1867	93	10	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Seamstress	Interior Decoratoring	Illinois	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Herman George Burkhardt	Sophia Maye	William Ashe

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 Address
No	None	Ruth Ashe, 4349 Olive

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) Congestive heart failure

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

DUE TO (c) 434.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebrovascular accident

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 3-25-61, to 3-27-61 and last saw her/him alive on 3-27-61

Death occurred at 10 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
David H. McKenna, M.D.	1515 LAFAYETTE AVE.	3-27-61

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	Mar. 30, 1961	Memorial Park Cemetery	St. Louis County, Missouri

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Ambruster Mortuary, 6633 Clayton Rd.	MAR 29 1961	Carl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.