

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-012035

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 687

AMENDED

FILED MAR 27 1961

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Normandy</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Normandy</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy, Mo.</u>	Length of stay in 1b <u>YRS.</u>	c. CITY OR TOWN <u>Normandy, Mo.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2800 Normandy Drive</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2800 Normandy Drive</u>

3. NAME OF DECEASED (Type or print) First <u>Sister</u> Middle <u>Mathias</u> Last <u>, C.C.V.I.</u>	4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1961</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-66</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>	11. BIRTHPLACE (City and state or country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Peter Treib</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ailoff</u>	14. NAME OF HUSBAND OR WIFE _____
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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) <u>No.</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Sister M. Scholastica</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Renal Vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input 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 Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from about 20 yrs 3-11-61 and last saw her alive on Feb 5, 1861  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John F. Flynn B.S.M.D.</u>	22b. ADDRESS <u>1715 St 39th St. St. Louis Mo</u>	22c. DATE SIGNED <u>3-11-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-13-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Incarnate Word Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
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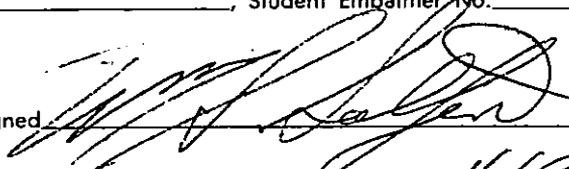
24. FUNERAL DIRECTOR <u>Arthur J. Donnelly Und Co</u> <u>3800 Lindell Blvd.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3-11-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

**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 \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 4699

P. O. Address 3840 Lund

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.