

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5016

1. PLACE OF DEATH  
 a. COUNTY \_\_\_\_\_  
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. Length of stay 3 mos. 24 days  
 c. CITY OR TOWN St. Louis Inside Limits Yes  No   
 d. STREET ADDRESS Fr. Jim's (If outside, give location) 3227 Washington Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First THEDA Middle \_\_\_\_\_ Last DEVRIES 4. DATE OF DEATH Month May Day 25 Year 1961

5. SEX Female 6. COLOR OR RACE White 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH 4-12-83 9. AGE (last birthday) 78 yrs. 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) formerly: Saleslady 10b. KIND OF BUSINESS OR INDUSTRY Drug Store 11. BIRTHPLACE (City and state or country) Hanover, Germany 12. CITIZEN OF WHAT COUNTRY Naturalized 1926

13a. FATHER'S NAME Jacob Devries 13b. MOTHER'S MAIDEN NAME Sophie ? 14. NAME OF HUSBAND OR WIFE \_\_\_\_\_

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. --- 17. INFORMANT State Hospital Records Address 5400 Arsenal

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Acute and healed myocardial infarcts  
 DUE TO (b) Atheromatous occlusions of left descending coronary artery.  
 DUE TO (c) Arteriosclerotic cardio-vascular-renal disease  
 Condition, if any, which gave rise to above cause (a), stating the underlying cause, if left: 5/13/61

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture left hip 3-13-61. 4201F  
 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.) Fell when getting out of bed.

20c. TIME OF INJURY Hour \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. Month, Day, Year 3-13-61

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.) St. Louis State Hospital 20f. CITY, TOWN, OR LOCATION St. Louis, Mo. COUNTY \_\_\_\_\_ STATE \_\_\_\_\_

21. I attended the deceased from 2-1-61 to 5-25-61 and last saw her alive on 5-25-61  
 Death occurred at L.N. McCullough, M.D. 7:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L.N. McCullough M.D. 22b. ADDRESS 5400 Arsenal St. 22c. DATE SIGNED 5-26-61

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 5/29/61 23c. NAME OF CEMETERY OR REPOSITORY United Hebrew Temple 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR Herman Rindskopf, Inc. ADDRESS 5216 Delmar 25. DATE RECD. BY LOCAL REG. MAY 29 1961 26. REGISTRAR'S SIGNATURE Loard Smith, M.D.

DATE AMENDED \_\_\_\_\_  
 INSTEAD OF \_\_\_\_\_  
 DOCUMENT \_\_\_\_\_  
 MEDICAL CERTIFICATION \_\_\_\_\_  
 SHOULD READ \_\_\_\_\_  
 BY AFFIDAVIT OF \_\_\_\_\_  
 ITEM NO. \_\_\_\_\_

**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 John Kottler  
Licensed Embalmer No. 3880

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.