SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-027263
STATE FILE NUMBER

AMENDED

Registration District No. 218 Primary Registration District No. 1003 Registrar's No. 6743

FILED JUL 26 1961

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE 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, Mo.
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): 3127 Locust
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: CLAUDIA Middle: Last: RICE

4. DATE OF DEATH Month: May Day: 7 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 11/11/1884

9. AGE (last birthday): 76

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): UNKNOWN

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): Ga.

12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Da vis, John

13b. MOTHER'S MAIDEN NAME: Sally Roberts

14. NAME OF HUSBAND OR WIFE: Robert

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

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: Claudia Rice
Address: 3127 Locust St. Lou is

MEDICAL CERTIFICATION

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)	PULMONARY EDEMA	HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	HEART FAILURE	YRS
DUE TO (c)	ANEMIC HEART DISEASE	YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4344

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 5/6/61 9: pm. to 5/7/61 and last saw ~~he~~ alive on 5/7/61.
Death occurred at 11:25 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Nicholas Ourf - M.D.

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 5/9/61

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

23b. DATE: 7-31-61

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

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

24. NAME OF FUNERAL DIRECTOR: Rowland-Acker Mortuary Service
ADDRESS: 4104 Manchester Ave.

25. DATE RECD. BY LOCAL REG.: JUL 20 1961

26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

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

BY AFFIDAVIT OF DOCUMENT

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 compl 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.