

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009718

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 483

FILED MAR 5 1963	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Ann</u> Length of stay in 1b _____	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>St. Louis, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>181 1/2 Grape Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>PRISCILLA</u> Middle _____ Last <u>BOLTE</u>	
4. DATE OF DEATH Month <u>FEB.</u> Day <u>12</u> Year <u>1963</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-1877</u> 85 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u> 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas Ruick</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or years) <u>No</u>	13b. MOTHER'S MAIDEN NAME <u>Ritter</u> 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Address <u>Florence Hannon 181 1/2 Grape Ave.</u>

18. CAUSE OF DEATH (Enter only one cause. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arterio-sclerotic Cardio-vascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ 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		INTERVAL BETWEEN ONSET AND DEATH <u>30men</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>NONE</u> 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 <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 _____	
21. I attended the deceased from <u>2-1-63</u> to <u>2-12-63</u> and last saw her/him alive on <u>2-5-62</u> Death occurred at: <u>1105 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Allen McDearney M.D.</u> 22b. ADDRESS <u>860 N. Woodlawn</u> 22c. DATE SIGNED <u>2-13-63</u> (State)	23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 23b. DATE <u>Feb. 14 1963</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> 23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>JOHN STYGAR & SON -- 5541 RIVERVIEW BLVD.</u>	25. DATE RECD. BY LOCAL REG. <u>2-13-63</u> 26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
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 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 USE BLACK INK OR TYPEWRITER RIBBON

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 *J. R. Ristie*

Licensed Embalmer No. 3980

P. O. Address St. Louis, Mo.

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.