

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041954

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10158 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 17 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 10-days	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Altenheim 5408 So. Broadway		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3525 Juniata		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Cora Ringling			4. DATE OF DEATH Month Day Year Oct. 12, 1963							
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/30/75	9. AGE (last birthday) 87	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) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.				
13a. FATHER'S NAME Christian Ringling			13b. MOTHER'S MAIDEN NAME Magdalena Sutter			14. NAME OF HUSBAND OR WIFE none				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. None		17. INFORMANT Cora Ringling - 3525 Juniata				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis								INTERVAL BETWEEN ONSET AND DEATH 8 days 3 hrs		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease								?		
DUE TO (c) Arteriosclerosis and Senescence										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertrophic Arthritis of Spine 420.0					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					
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"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) none						
20c. TIME OF INJURY Hour s.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.) St Louis		20f. CITY, TOWN, OR LOCATION COUNTY STATE Mo		
21. I attended the deceased from Oct 3 1963 to Oct 12 1963 and last saw her alive on Oct 12 1963 Death occurred at 10/12/63 3:20 A. m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE May Stubbiff MD (Degree or title)					22b. ADDRESS 512 Doran Place			22c. DATE SIGNED 10/12/63 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 15, 1963		23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery		23d. LOCATION (City, town, or county) St. Louis, Missouri				
24. FUNERAL DIRECTOR WACKER-HELDERLE-3634 Gravois Ave.				25. DATE RECD. BY LOCAL REG. OCT 14 1963		26. REGISTRAR'S SIGNATURE Roald Smith, M.D.				

DATE AMENDED
2
INSTEAD OF
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
86
ITEM NO. SHOULD READ
BY AFFIDAVIT OF

DOCUMENT
MEDICAL CERTIFICATION

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 Delia J. Krissin

Licensed Embalmer No. 3497

P. O. Address St. Louis

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.