

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041956

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10504

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 31 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>less than 24 hrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Masonic Home 5351 Delmar Blvd.</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>H.</b> Last <b>Rinker</b>						4. DATE OF DEATH Month <b>10</b> Day <b>19</b> Year <b>63</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1/7/77</b>		9. AGE (last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Ret.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>R.R. Auditing Dept. Phillipsburg, N.J.</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Edward Rinker</b>				13b. MOTHER'S MAIDEN NAME <b>Kate Doile</b>				14. NAME OF HUSBAND OR WIFE <b>Clara Rinker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Carl Stein, 5351 Delmar Blvd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of right hip;</b> <b>Generalized Arterio Sclerosis; suffered in</b> <b>fall in home (Masonic) on October 18, 1963</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>accident 904.7-45</b>										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 checked="" 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.) <b>See above</b>							
20c. TIME OF INJURY Hour <b>?</b> a.m. <b>?</b> p.m. <b>?</b>		Month, Day, Year <b>10-18-63</b>									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Masonic Home 12</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo</b>		COUNTY <b>Mo</b>		STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>4:30</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <b>Helen L. Taylor</b> (Degree or title) <b>Coroner</b>						22b. ADDRESS <b>1300 Clark Ave.</b>			22c. DATE SIGNED <b>10-22-63</b> (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>10/23/63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis County</b>		Mo.			
24. FUNERAL DIRECTOR <b>Drehmann-Harral</b> ADDRESS <b>1905 Union</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 22 1963</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>					

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 Albert R. Thompson

Licensed Embalmer No. 4257

P. O. Address H. Jones

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.