

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-049886

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12311** STATE FILE NUMBER

FILED DEC 20 1963

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 8 hrs 15 minutes	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospitals, Inc.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1600 Big Bend Blvd.,
3. NAME OF DECEASED (Type or print) First Raymond Middle G. Last Rettig			4. DATE OF DEATH Month Dec. Day 10, Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1902
9. AGE (last birthday) 60 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager-Apparatus & Service Shop-General Electric Co. Cincinnati, Ohio		10b. KIND OF BUSINESS OR INDUSTRY U.S.A.	11. BIRTHPLACE (City and state or country) U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Herman W. Rettig Sr.	
13b. MOTHER'S MAIDEN NAME Emma K. Zimmermann		14. NAME OF HUSBAND OR WIFE Margaret A. Rettig	
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 Margaret E. Rettig 1600 Big Bend Blvd.		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) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 9 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardio-vascular disease			?
DUE TO (c) 443 X			
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
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 _____ 1950 to Dec. 10, 1963 and last saw him alive on Dec. 10, 1963 Death occurred at 8:15 P.M., _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul J. Keffler M.D.		22b. ADDRESS 1755 South Grand Blvd.,	22c. DATE SIGNED Dec 11 1963
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 13, 1963	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Kriegshauser Mortuaries-4228 So. Kingshighway		25. DATE REC'D. BY LOCAL OFFICE DEC 12 1963	26. REGISTRAR'S SIGNATURE Paul Smith M.D.

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
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 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

R. N. Stover

Licensed Embalmer No.

4007

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.