

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030873

STATE FILE NUMBER

7808

9

HEALTH, WELFARE, PUBLIC SERVICE

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7808

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR St. Louis 0 Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR IN INSTITUTION Cardinal Glennon Hosp. 224		d. STREET ADDRESS (If outside, give location) 3802 Minnesota Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WALLY LUPE QUINTANILLA		4. DATE OF DEATH Month Day Year 8 10 58	
5. SEX Male 6	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> 0 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-1945
9. AGE (In years last birthday) 13		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) 0 St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Martin Quintanilla	
14. MOTHER'S MAIDEN NAME Linda Munoz		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 Address Martin Quintanilla, 3802 Minnesota	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse encephalitis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 343X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			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 Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT <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 July 15 to Aug 10 and last saw her alive on Aug 10 Death occurred at 7:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Paul A. Byrne M.D.		22b. ADDRESS Card. Glennon Hospital	22c. DATE SIGNED Aug 10
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-13-1958	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette		25. DATE RECD. BY LOCAL REG. AUG 1 1958	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

pector, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-56

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 *James R. Chapman*.....

Licensed Embalmer No. *45*.....

P. O. Address *St. La*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.