

XC-5 201 413 FILED VS AUG 3 1959  
 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1919 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>COLE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		Length of stay in 1b <b>133 Days</b>	c. CITY OR TOWN <b>JEFFERSON CITY</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Vet. Administration Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>P.O. BOX 813</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>PAUL</b> Last <b>CHOATE</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>17</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-02</b>	9. AGE (last birthday) <b>57</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SURVEYOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>FREDERICKTOWN, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>JOHN CHOATE</b>		13b. MOTHER'S MAIDEN NAME <b>MARY HEATHERLY</b>		14. NAME OF HUSBAND OR WIFE -----	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-2</b>	16. SOCIAL SECURITY NO. <b>490-097-741</b>	17. INFORMANT <b>VA HOSP. RECORDS, JEFFERSON BARRACKS, MO.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION WITH MURAL THROMBUS</b>		<b>5 to 6 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>	<b>3 to 4 years</b>
	DUE TO (c)	

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	
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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 3-6-59 to 7-17-59 and ~~was present at~~  
 Death occurred at 5:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>W. Oppler, (Dr. Prof. Services)</b>		22b. ADDRESS <b>M.D. VA HOSP. JEFFERSON BARRACKS, MO.</b>		22c. DATE SIGNED <b>7-17-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>7-17-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson City, Missouri</b>	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington</b>		25. DATE RECD. BY LOCAL REG. <b>7-17-59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 2 1959

AUG 28 1959

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*J. M. Dinkley*

Licensed Embalmer No. 365

P. O. Address H. Lou 8

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