

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038293

FILED VS NOV 2 1959

Registration District No. 317

Primary Registration District No. 541

Registrar's No.

2754 STATE FILE NUMBER

INDEXED

|   |   |   |   |   |   |  |
|---|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ST LOUIS</u>  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u> |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWNSHIP <u>CLAYTON</u>   |   | Length of stay in 1b<br><u>DOA</u>  | c. CITY OR TOWN <u>ST. JOHN</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS CO HOSPITAL</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <u>8713 DAVID</u>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First <u>ANNE</u> Middle <u>MUNRO</u> Last <u>MUNRO</u>  |   |   | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>14</u> Year <u>1959</u>   |   |   |  |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-21-1890</u>  | 9. AGE (last birthday)<br><u>69</u>                     | IF UNDER 1 YEAR<br>Months _____ Days _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWORK</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>   | 11. BIRTHPLACE (City and state or country)<br><u>GALT ONTARIO</u>   | 12. CITIZEN OF WHAT COUNTRY<br><u>CANADIANS</u>         |   |  |
| 13a. FATHER'S NAME<br><u>William Poblock</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>AGNES MURRAY</u>  |   | 14. NAME OF HUSBAND OR WIFE<br><u>GARFIELD MUNRO</u>    |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, (or unknown)) (If yes, give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  | 17. INFORMANT<br>Address <u>Poblock 8713 DAVID</u>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Myocarditis &amp; Fibrillation</u> <u>5 months</u><br>DUE TO (c) <u>Arterio-Sclerosis</u> <u>years</u><br>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?<br>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.)  |   |   |   |  |
| 20c. TIME OF INJURY<br>Hour _____<br>a.m. _____<br>p.m. _____   |   |   |   |   |   |  |
| 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 <u>May 1959</u> to <u>10/14/59</u> and last saw her <u>7/10/59</u> alive on<br>Death occurred at <u>7:00 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |   |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Dugh Haynes</u>  |   |   | 22b. ADDRESS<br><u>3720 Washington</u>  |   | 22c. DATE SIGNED<br><u>10/18/59</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE<br><u>10-19-59</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>LAUREL Hill</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>ST LOUIS CO MO</u>  |   |   |  |
| 24. FUNERAL DIRECTOR<br><u>Earl Hilleman</u>  |   | ADDRESS<br><u>9709 BACKLAND</u>   | 25. DATE RECD. BY LOCAL REG.<br><u>10-18-59</u>   | 26. REGISTRAR'S SIGNATURE<br><u>John B. Murphy M.D.</u> |   |  |

BY AFFIDAVIT OF attending physician MEDICAL CERTIFICATION DOCUMENT

DEC 14 1950

**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 *Frank Allen*

Licensed Embalmer No. *3507*  
P. O. Address *Belmont, Mass*

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.