

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038516

FILED VS NOV 16 1959 317

Registration District No. 500 Registrar's No. 2848

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch, Mo.</b>		c. CITY OR TOWN <del>St. Louis</del> <b>Brentwood</b>	
Length of stay in 1b <b>216 days</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>Robert Koch Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>8812 Bridgeport Ave.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>C.</b> Last <b>Quail</b>			4. DATE OF DEATH Month <b>Oct</b> Day <b>25</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-2-88</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, or during life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sporting Goods</b>		11. BIRTHPLACE (City and state or country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>

13a. FATHER'S NAME <b>Robert Quail</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Krause</b>	14. NAME OF HUSBAND OR WIFE <b>Charlotte Quail</b>
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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>492-05-4819</b>	17. INFORMANT <b>Medical Records Koch Hospital</b>	Address <b>Koch, Mo.</b>
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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: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <b>Pulmonary Tuberculosis</b>	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 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 Hour _____ a.m. _____ p.m.	Month, Day, Year _____	

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.)	20f. CITY, TOWN, OR LOCATION <b>Koch, Mo.</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>Mar. 3, 1959</b> to <b>Oct. 25, 1959</b> and last saw him alive on <b>Oct. 25, 1959</b>				
Death occurred at <b>3:10 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>Bernard Sudman M.D.</i>	(Degree or title)	22b. ADDRESS <b>Koch Hospital, Koch, Mo.</b>	22c. DATE SIGNED <b>10-26-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-29-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kirkwood, Mo.</b>
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24. FUNERAL DIRECTOR <b>JAY B. SMITH, MAPLEWOOD, MO.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-27-59</b>	26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 J.P. Burgess

Licensed Embalmer No. 4029  
P. O. Address Maplewood

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.