

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

875057 SL 170 FILED VS NOV 3 0 1959

59-042060

STATE FILE NUMBER

210638

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>RANDOLPH</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>915 N GRAND ST LOUIS, MO</u>		Length of stay in 1b <u>5</u>		c. CITY OR TOWN <u>TILDEN</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET ADM. HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>NONE</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY C JUENGER</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 17, 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-95</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u> Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (City and state or country) <u>NASHVILLE, TENN.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>MIKE JUENGER</u>		13b. MOTHER'S MAIDEN NAME <u>AUGUSTA RIEL</u>		14. NAME OF HUSBAND OR WIFE <u>MIDA JUENGER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT Address <u>VA HOSP. RECORDS, ST. LOUIS, MO.</u>				
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)			<u>EMPHYSEMA OBSTRUCTIVE WITH PULMONARY INSUFFICIENCY</u>				<u>YEARS</u>
DUE TO (b)			<u>BRONCHIECTASIS</u>				<u>YEARS</u>
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
<u>COR PULMONALE</u>							
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 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. Attended the deceased from <u>11/12/59</u> to <u>11-17-59</u> and last saw <u>BE</u> him alive on <u>11-17-59</u>							
Death occurred at <u>8:55 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>LEO T. NEWJR. M.D.</u>			(Degree or title)			22b. ADDRESS <u>VAH, ST. LOUIS, MO.</u>	22c. DATE SIGNED <u>11-17-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LENZBURG CEMETERY</u>		23d. LOCATION (City, town, or county) <u>ILLINOIS</u>			
24. FUNERAL DIRECTOR <u>LYN N FUNERAL HOME, SPARTA, ILLINOIS</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>NOV 18 1959</u>	26. REGISTRAR'S SIGNATURE <u>Carol Smith, M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

3. 02

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 *Robert M. Murray*

Licensed Embalmer No. 3749

P. O. Address St Louis

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.