

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042789

FILED VS DEC 3 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2987

ENDED

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u> Length of stay in 1b <u>DOA</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST LOUIS</u> c. CITY OR TOWN <u>ALLEN TON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Box 33</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS COUNTY Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE J. JUNGE</u>			4. DATE OF DEATH Month Day Year <u>Nov. 6 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>SEPT. 1, 1907</u>	9. AGE (last birthday) <u>52</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SO GOOD POTATOE</u>		11. BIRTHPLACE (City and state or country) <u>PACIFIC MO</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>ALBERT JUNGE</u>		13b. MOTHER'S MAIDEN NAME <u>KATIE SWAYNE</u>		
14. NAME OF HUSBAND OR WIFE <u>LEONA JUNGE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		
17. INFORMANT Address <u>LEONA JUNGE ALLEN TON Mo</u>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
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)		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 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 _____ to _____ and last saw her/him alive on _____
 Death occurred at 4P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or file)
John C. Murphy M.D. Asst. Health Commissioner

22b. ADDRESS 801 S. Brentwood Clayton, Mo.

22c. DATE SIGNED _____

23a. REMOVAL	23b. DATE <u>Nov. 10 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kute 2906 Grassie</u>		25. DATE RECD. BY LOCAL REG. <u>11-9-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

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 _____

Licensed Embalmer No. 4347

P. O. Address 2906

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.