

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

59-042839

FILED VS DEC 3 1959 317

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3072

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>ST LOUIS</b>	a. STATE <b>MO</b>	b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>RICHMOND HEIGHTS</b>	Length of stay in 1b <b>6 DAYS</b>	c. CITY OR TOWN <b>UNIVERSITY CITY</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>ST MARY HOSPITAL</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1530 TEASDALE</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <b>CARROLL</b>	Middle <b>M</b>	Last <b>AWALT</b>	Month <b>NOV</b>	Day <b>18</b> Year <b>1959</b>
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>NOV 4, 1902</b>	9. AGE (last birthday) <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRODUCTION MGR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MOLONEY ELE</b>	11. BIRTHPLACE (City and state or country) <b>ELDORADO, ILL</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
13a. FATHER'S NAME <b>GEORGE AWALT</b>		13b. MOTHER'S MAIDEN NAME <b>GERTRUDE SIMMONS</b>		14. NAME OF HUSBAND OR WIFE <b>LUCILLE AWALT</b>
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>499-10-5697</b>	17. INFORMANT Address <b>LUCILLE AWALT 7530 TEASDALE</b>	

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>Tumor of Brain involving medulla &amp; cerebellum.</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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>X</b>
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 COUNTY STATE _____
21. I attended the deceased from <b>Aug 9, 1959</b> to <b>Nov 17, 1959</b> and last saw him alive on <b>11/17/59</b> . Death occurred <b>St Mary's Hosp 12:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <b>R. Mueller M.D.</b>	22b. ADDRESS <b>4161 Linden Blvd</b>	22c. DATE SIGNED <b>11/18/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>NOV 30, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST JOSEPH CEMETERY</b>
23d. LOCATION (City, town, or county) <b>RIDGEWAY ILL</b>		

24. FUNERAL DIRECTOR ADDRESS <b>STOCK MORTUARY 8895 BRENTWOOD CLAYTON 5</b>	25. DATE RECD. BY LOCAL REG. <b>11-19-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 Paul Q. Wachter

Licensed Embalmer No. 4787

P. O. Address St. Louis 7

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.