URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

'59 045395

STATE FILE NUMBER

Registration District No. SL 19395--- XC 3955995 Primary Registration District No. _____ Registrar's 211796

FILED VS JAN - 4 1960

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO.
Length of stay in 1b: 43 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VET ADM HOSPITAL
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: OKLAHOMA b. COUNTY
c. CITY OR TOWN: OKLAHOMA CITY
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 102 W. RENO
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First HERBERT Middle CECIL Last DUREN
4. DATE OF DEATH: Month DECEMBER Day 19 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-1-14
9. AGE (last birthday): 45
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): MADILL, OKLAHOMA
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: CHARLIE DUREN
13b. MOTHER'S MAIDEN NAME: MARY E. DUNCAN
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 457-14-4063
17. INFORMANT: VA HOSPITAL REC Address: ST. LOUIS, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): PULMONARY TUBERCULOSIS — YEARS
DUE TO (c): 002x
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. VA attended the deceased from 11-6-59, to 12-19-59 and last saw him alive on 12-19-59
Death occurred at 1:18 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): RALPH H. BENDER M.D.
22b. ADDRESS: VAH, 915 N. GRAND ST. LOUIS, MO.
22c. DATE SIGNED: 12-20

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 12-21-59
23c. NAME OF CEMETERY OR CREMATORY: Mid-West City, Okla
23d. LOCATION (City, town, or county) (State): Midwest City, Okla.
24. FUNERAL DIRECTOR: Edward Fendler Mortuary ADDRESS: 5611 So.Grand
25. DATE RECD. BY LOCAL REG.: DEC 21 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed J. A. Hungborg

Signature of Student Embalmer

Licensed Embalmer No. 4772

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.