

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS JAN 15 1960

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Registration District No. _____ Primary Registration District No. _____ Registrar's No. **212160** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS 4053 HARTFORD	

3. NAME OF DECEASED (Type or print) First Gerald Middle Last Joyce	4. DATE OF DEATH Month December Day 29th , Year 1959
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH AUG. 19 1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CABINET MAKER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) WISCONSIN	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME GILBERT JOYCE	13b. MOTHER'S MAIDEN NAME ALICE FINNEGAN	14. NAME OF HUSBAND OR WIFE ETHEL JOYCE
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT ETHEL JOYCE	Address 4053 HARTFORD
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute Peritonitis		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) mesenteric thrombosis	
	DUE TO (c) dissecting aneurysm of aorta	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 451X		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

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____

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
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21. I attended the deceased from 12-28-59 2:20 P.M. to 12-29-59 and last saw her/him alive on 12-29-59 Death occurred at 6:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE R. L. M. Alench, M.D.	(Degree or title)	22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 12-29-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JAN. 2 1959	23c. NAME OF CEMETERY OR CREMATORY S. S. PETER & PAUL	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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24. GENERAL DIRECTOR Thomas Kates 2906 Gravois	25. DATE RECD. BY LOCAL REG. DEC 31 1959	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.
Student _____
Signature of Student Embalmer

Signed James C. Will

Licensed Embalmer No. 434

P. O. Address 2906 S

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