

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 2 7 4

FILED VS. JAN 15 1960

317

Primary Registration District No. 547

Registrar's No. 3402

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Hts.</u>		Length of stay in 1b <u>12 Days</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3922 Randall St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle _____ Last <u>ERNIE</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-1880</u>		9. AGE (last birthday) <u>79</u>	
						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) <u>Furniture Dealer (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>(Retired)</u>		11. BIRTHPLACE (City and state or country) <u>Sullivan, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jacob Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Barbara Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Late Anna Ernie</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>499-36-8464</u>		17. INFORMANT <u>Ruth M. Jackman</u> Address <u>Affton, Mo. 8628 Charlton Lane</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 Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>420.0</u>								INTERVAL BETWEEN ONSET AND DEATH <u>few years</u>	
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			
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. I attended the deceased from <u>11/3 8/55</u> to <u>12/18/59</u> and last saw him alive on <u>12/18/59</u> Death occurred at <u>9:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>R. Napady, MD</u> (Degree or title)				22b. ADDRESS <u>Medical West Bldg</u>		22c. DATE SIGNED <u>12/21/59</u> (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 22, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u> (State)			
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S. Kingshighway</u>				25. DATE RECD. BY LOCAL REG. <u>12-21-59</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy, M.D.</u>			

DOCUMENT

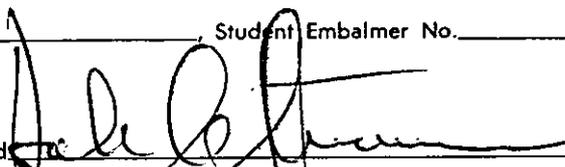
MEDICAL CERTIFICATION

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
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4533

P. O. Address _____

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.