

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

'59 0 4 6 4 3 2  
STATE FILE NUMBER

FILED VS. JAN 8 1960 317

Registration District No. 500 Primary Registration District No. 500 Registrar's No. 3168

UNRECORDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Manchester</b>		Length of stay in 1b <b>MONS.</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Manchester Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6958 Chippewa</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Mense</b> Last <b>Mense</b>			4. DATE OF DEATH Month <b>November</b> Day <b>26</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>11/7/1898</b>	9. AGE (last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mfg. department</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>chemical</b>		11. BIRTHPLACE (City and state or country) <b>Fayetteville, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Henry Mense</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Janning</b>		14. NAME OF HUSBAND OR WIFE <b>Florence</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>493-10-2418</b>		17. INFORMANT <b>Florence Mense</b>		Address <b>6958 Chippewa</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>Profuse Intestinal Hemorrhage</b>						<b>5 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cancer of the Colon</b>						<b>6 months</b>		
DUE TO (c) <b>153.8</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senility, Emaciation</b>						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 <b>Nov. 24th, 59</b> 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>Nov. 28 1958</b> to <b>Nov. 24th, 59</b> and last saw him alive on <b>Nov. 24, 59</b>		Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Robert W. Laffey, R.O.</b> (Degree or title)			22b. ADDRESS <b>Box 122, Manchester</b>			22c. DATE SIGNED <b>11-27-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>11/30/1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>		
24. FUNERAL DIRECTOR <b>John L Ziegenhein &amp; Sons 7027 Gravois</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>11-30-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>	

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 Donald Benz

Licensed Embalmer No. 4983

P. O. Address St. Louis Mo

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.