

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003288

XC-2403 008 SL 21218

2 948

STATE FILE NUMBER

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

FILED VS FEB 5 1960

NDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JEFFERSON							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		Length of stay in 1b 20 days		c. CITY OR TOWN RUSH TOWER		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) - - - - -		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM P. DANIELS			4. DATE OF DEATH Month Day Year JANUARY 26, 1960								
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/22/69	9. AGE (last birthday) 90	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) CONSTRUCTION WORKER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Piedmont, Mo.		12. CITIZEN OF WHAT COUNTRY USA				
13a. FATHER'S NAME THOMAS J. DANIELS			13b. MOTHER'S MAIDEN NAME SARAH KIENS			14. NAME OF HUSBAND OR WIFE - - - - -					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES SPAN			16. SOCIAL SECURITY NO.		17. INFORMANT Address Jacob Daniels, Rush Tower, Missouri						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MESENTERIC THROMBOSIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) 450.0 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								INTERVAL BETWEEN ONSET AND DEATH 1 WEEK			
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. attended the deceased from 1/6/60 to 1/26/60 and last saw him alive on 1/26/60 Death occurred at 7:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) Paul M. Smith, M.D.				22b. ADDRESS VAH, ST. LOUIS, MO.				22c. DATE SIGNED 1/26/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-28-60		23c. NAME OF CEMETERY OR CREMATORY Roselawn Memorial Park		23d. LOCATION (City, town, or county) Festus Mo					
24. FUNERAL DIRECTOR Vinyard Funeral Home, Inc., Festus, Mo				25. DATE RECD. BY LOCAL REG. JAN 27 1960		26. REGISTRAR'S SIGNATURE Paul M. Smith, M.D.					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

77.9.13

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 *[Handwritten Signature]*

Licensed Embalmer No. 3012

P. O. Address *[Handwritten 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.