

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 11 1960

**60-003355**  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **704**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St Louis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Length of stay in 1b <b>8 hrs</b>		c. CITY OR TOWN <b>Florissant</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Glennon Memorial</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3065 Blackwood</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MICHAEL ANDREW ELMORE</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>20,</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-19-60</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours <b>76</b> Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Richmond Heights, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>William E. Elmore</b>			13b. MOTHER'S MAIDEN NAME <b>Betty Fishback</b>			14. NAME OF HUSBAND OR WIFE <b>None</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>none</b>		17. INFORMANT Address <b>Wm. E. Elmore, Florissant, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGENITAL HEART DISEASE</b>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>754-5</b>								
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 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 <b>11/19/60</b> to <b>11/20/60</b> and last saw her/him alive on <b>11/20/60</b> . Death occurred at <b>11/20/60 6 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>James R. Canale, M.D.</b>				22b. ADDRESS <b>950 Francis Place, Clayton</b>			22c. DATE SIGNED <b>11/20/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-21-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>The Florissant, Mortuary, Florissant, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>JAN 20 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <i>mjb</i>			

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 Gene A. Suttchen

Licensed Embalmer No. 4966

P. O. Address Missouri

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.