

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-003556

2 1263

STATE FILE NUMBER

FILED VS FEB 11 1960

Registration District No.

Primary Registration District No.

Registrar's No.

INDEXED

|   |  |   |  |   |  |  |   |   |                                   |  |  |                 |  |
|---|--|---|--|---|--|--|---|---|-----------------------------------|--|--|-----------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |  |  |   |   |                                   |  |  |                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN<br><b>St. Louis</b>   |  | Length of stay in 1b<br><b>1 day</b>  |  | c. CITY OR TOWN<br><b>St. Louis</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |   |                                   |  |  |                 |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>Little Flower Conv. Home</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>3830 Park Avenue</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |                                   |  |  |                 |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Joseph C. Holmes</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>February 2, 1960</b>   |  |  |   |   |                                   |  |  |                 |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Caucasian</b>  |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/7/1884</b>  |   | 9. AGE (last birthday)<br><b>75</b>                             |                                   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HR. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Express Messenger</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railway Express</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>Chester, Illinois</b>               |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                       |                                   |  |  |                 |  |
| 13a. FATHER'S NAME<br><b>George Holmes</b>  |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><b>(unknown)</b>   |  |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Leah Holmes (nee Richard)</b> |                                   |  |  |                 |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>714-03-2982</b>   |  | 17. INFORMANT<br>Address<br><b>Mrs. Leah Holmes, 3830 Park Ave., St. Louis</b>       |   |   |                                   |  |  |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE 1 WK</b><br>DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE 1 yr</b><br>DUE TO (c) <b>4200</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |   |  |  |   |   |                                   | INTERVAL BETWEEN ONSET AND DEATH   |  |                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease, condition given in PART I (a)<br><b>PULMONARY EMPHYSEMA</b>  |  |   |  |   |  |  |   |   |                                   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |                 |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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>June 10, 1959</b> to <b>FEB 2, 1960</b> and last saw <sup>her</sup> him alive on <b>JAN 31, 1960</b><br>Death occurred at <b>7:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |  |   |  |  |   |   |                                   |  |  |                 |  |
| 22a. SIGNATURE (Degree or title)<br><b>John T. Vander MS</b>  |  |   |  |   |  | 22b. ADDRESS<br><b>1504 SO GRAND BLVD</b>  |   |   | 22c. DATE SIGNED<br><b>2/3/60</b> |  |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2/5/1960</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Valhalla Crematory</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Missouri</b>   |   |   |                                   |  |  |                 |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Hoffmeister Colonial Mortuary<br/>6464 Chippewa Street St. Louis, Mo.</b>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 3 1960</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Leah Smith 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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bill G. Drummond

Licensed Embalmer No. 4-769

P. O. Address St Louis

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.