

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004168

FILED VS. FEB 10 1960

2 1136

STATE FILE NUMBER

INDEXED

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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                         |  | Length of stay in 1b<br><b>1 day</b>   | c. CITY OR TOWN <b>St. Louis</b><br>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 <b>Firmin Desloge Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   | d. STREET ADDRESS (If outside, give location)<br><b>4127 a N. 20th, 7</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |                                  |   |   |   |  |
|--|----------------------------------|---|---|---|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Arthur</b> Last <b>Triplett</b>       |                                  |   | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>31</b> Year <b>60</b> |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-31-60</b>                              | 9. AGE (last birthday)<br><b>22</b>                                 | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                         |

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|---|--|--|--|---|--|
| 13a. FATHER'S NAME<br><b>Dennis Ray Triplett</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Sharon Faye Howell</b> |  | 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)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>                 |  | 17. INFORMANT Address<br><b>Sharon Faye Triplett - 4127a N. 20th, 7</b> |  |

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|--|--|--|--|
| 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>Neonatal Alectriani</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to above cause - (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <b>762.5</b>                |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Feematecty</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 |

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| 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.<br>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<br><b>St. Louis</b> | COUNTY<br><b>St. Louis</b> | STATE<br><b>Mo.</b> |
| 21. I attended the deceased from <b>with 1/30/60</b> , to <b>death 1/31/60</b> and last saw him alive on <b>1/31/60</b><br>Death occurred at <b>2 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |  |                            |                     |

|   |                                  |   |   |                                   |
|---|----------------------------------|---|---|-----------------------------------|
| 22a. SIGNATURE (Degree, title)<br><b>R. Beaudoin M.D.</b>           |                                  | 22b. ADDRESS<br><b>1465 So Grand St. Louis</b>            |   | 22c. DATE SIGNED<br><b>2/1/60</b> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL - MOTOR</b> | 23b. DATE<br><b>FEB. 1, 1960</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LAKEVIEW CEM</b> | 23d. LOCATION (City, town, or county) (State)<br><b>JOHNSTON CITY, IA</b> |                                   |

|  |   |   |
|--|---|---|
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Siedmeyer &amp; Sons 3934 N. 20th St.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 1 1960</b> | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith M.D.</b> |
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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 Elton H. Penelucio

Licensed Embalmer No. 7283

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.