

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004318

FILED VS. FEB 1 1960 317

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 541 Registrar No. 95

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in 1b <u>DAYS</u>	c. CITY OR TOWN <u>Unk.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hosp.</u>		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 <u>Mary</u> Middle _____ Last <u>Caho</u>			4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>60</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>unk.</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk.</u>		11. BIRTHPLACE (City and state or country) <u>unk.</u>		12. CITIZEN OF WHAT COUNTRY <u>unk.</u>
13a. FATHER'S NAME <u>unk.</u>		13b. MOTHER'S MAIDEN NAME <u>unk.</u>		14. NAME OF HUSBAND OR WIFE <u>August Caho</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT Address <u>St. Louis County Hospital, Clayton 5, Mo.</u>		

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) <u>Liver failure</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hepatitis</u>	
DUE TO (c) _____		

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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. I attended the deceased from 12-14-59 to 1-1-60 and last saw her/him alive on 1-1-60  
Death occurred at 9:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Curtis J. Pugh, M.D.</u> (Degree or title)	22b. ADDRESS <u>6015 Brentwood, Mo.</u>	22c. DATE SIGNED <u>1-4-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY
<u>Anatomical</u>	<u>1/8/60</u>	<u>Anatomical</u>
23d. LOCATION (City, town, or county) (State)		

24. FUNERAL DIRECTOR <u>Rowland-Aker Mortuary Service</u> 4104 Manchester Ave. St. Louis 10, Mo.	25. DATE RECD. BY LOCAL REG. <u>1-11-60</u>	26. REGISTRAR'S SIGNATURE <u>J. H. ...</u>
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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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.