

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960

60-004485

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 184

| | | | | | | | | |
|---|---|---|--|---|---|---|---|--|
| 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 <u>ST LOUIS</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEBSTER GROVES</u> | | Length of stay in 1b <u>10 YRS</u> | | c. CITY OR TOWN <u>WEBSTER GROVES</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>541 W. LOCKWOOD AVE</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>541 W. LOCKWOOD AVE</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>DOVIC</u> Middle <u>BELLE</u> Last <u>KILLDAY</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1960</u> | | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</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>12-17-1872</u> | 9. AGE (last birthday) <u>87</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INVALID</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (City and state or country) <u>FREDERICKTOWN Mo</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>WILLIAM TUBBS</u> | | | 13b. MOTHER'S MAIDEN NAME <u>JULIA M. WHITE</u> | | 14. NAME OF HUSBAND OR WIFE <u>THOMAS KILLDAY</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT Address <u>Hubert Lewis</u> <u>Home Killday 541 West Lockwood Ave Mo.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u> </u> | | DUE TO (c) <u> </u> | | 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 | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>Hypertension Obesity</u> | | | | | | | 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 | |
| 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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> | 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 <u>1958</u> , to <u>1-14-60</u> and last saw her <u>him</u> alive on <u>1-14-60</u> Death occurred at <u>5:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>E. J. Vallon</u> | | | | 22b. ADDRESS <u>53 W. Big Bend</u> | | 22c. DATE SIGNED <u>1-18-60</u> | | |
| 23a. NAME OF CREMATION, BURIAL, OR INTERMENT <u>REMOVAL</u> | 23b. DATE <u>1-20-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u> | | 23d. LOCATION (City, town, or county) (State) <u>St Louis Mo.</u> | | 24. FUNERAL DIRECTOR <u>MITTEBERG</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>WEBSTER GROVES Mo</u> | | | 25. DATE RECD. BY LOCAL REG. <u>1-19-60</u> | | REGISTRAR'S SIGNATURE <u>John B. Murphy</u> | | | |

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

J W M Binkley

Licensed Embalmer No. *2653*

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.