

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008023

FILED VS. MAR 11 1960

2 2607

STATE FILE NUMBER

ENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis-Little Rock Hosp Inc.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Northwestern Hotel Natural Bridge &amp; Euclid</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Charles</b> Last <b>Carlin</b>			4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-5-1885</b>	9. AGE (last birthday) <b>75</b>	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) <b>Pensr. Motorman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>Chillicothe, Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Thomas Garlin</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Unknown</b>		14. NAME OF DECEASED'S WIFE <b>Emma Carlin</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>702-09-1154</b>	17. INFORMANT <b>Mrs. Emma Carlin</b>	Address <b>4919 Natural Bridge</b>
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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>UREMIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>
DUE TO (b) <b>nephrosclerosis, chronic</b>		
DUE TO (c) <b>ARTERIOSCLEROSIS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>MYOCARDIAL FIBROSIS</b>		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 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.)
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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 _____
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21. I attended the deceased from <b>Feb. 7, 1960</b> to <b>March 4, 1960</b> and last saw <sup>XX</sup> him alive on <b>March 3, 1960</b> Death occurred at <b>7:25 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>R.C. Meenan, M.D.</b>	22b. ADDRESS <b>McPac. Hospital 1755 S. Grand Blvd.</b>	22c. DATE SIGNED <b>3/5/60</b>
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23a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION <b>Removal</b>	23b. DATE <b>3-7-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Stanton Mem. Cem.</b>	23d. LOCATION (City, town, or county) <b>Stanton, Illinois</b>
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24. FUNERAL DIRECTOR <b>Subdmyer &amp; Sons</b>	ADDRESS <b>3934 N. 20th</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 5 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

7

**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 Robert Remelius

Licensed Embalmer No. 4283

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.