

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008586

FILED VS MAR 8 1960

2 2419

STATE FILE NUMBER

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 <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ENROUTE Mo. PAC. Hosp.</i>		d. STREET ADDRESS (If outside, give location) <i>3104 KEOKUK</i>	

3. NAME OF DECEASED (Type or print) First <i>AIMEE</i> Middle <i>MARTIN</i> Last			4. DATE OF DEATH Month <i>FEB.</i> Day <i>27</i> Year <i>1960</i>		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT. 23 1875</i>	9. AGE (last birthday) <i>84</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Mo</i>	
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13a. FATHER'S NAME <i>JACOB BEYNON</i>		13b. MOTHER'S MAIDEN NAME <i>PHILOMENA CABRILLAC</i>	
14. NAME OF HUSBAND OR WIFE <i>JAMES T. MARTIN (DEC)</i>		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. <i>NONE</i>	
17. INFORMANT <i>ADELE BOYD</i>		Address <i>3104 KEOKUK</i>			

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) <i>Broncho pneumonia</i>			<i>1 week</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Arterio-sclerotic heart disease</i>		<i>2 yrs.</i>
	DUE TO (c) <i>Generalized arterio-sclerosis</i>		<i>5 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4200</i>			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 _____ 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 <i>Feb. 18, 1960</i> to <i>Feb. 27, 1960</i> and last saw her <i>alive</i> on <i>Feb. 25, 1960</i> Death occurred at <i>1:30 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <i>S. R. Sheridan, M.D.</i>		22b. ADDRESS <i>#16 Hampton Village Plaza</i>		22c. DATE SIGNED <i>3-1-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>MAR. 3 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>DELLEFONTAINE CEM.</i>	23d. LOCATION (City, town, or county) <i>ST. LOUIS Mo</i>	(State)
24. FUNERAL DIRECTOR <i>Thomas Lutes 2906 Gravois</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 1 1960</i>	26. REGISTRAR'S SIGNATURE <i>Leon Smith, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m b c.

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 James C. Hill

Licensed Embalmer No. 43471
P. O. Address 2906

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.