

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013541

FILED VS MAR 3 0 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 788

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>ST Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton Mo</b>		Length of stay in 1b <b>1mo. 4days</b>		c. CITY OR TOWN <b>Riverview Gardens</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Co. Hosp</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>535 Leeton Ave</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Heag</b> Last <b>Hegg</b>				4. DATE OF DEATH Month <b>3</b> Day <b>4</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 18-1893</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life/ even if retired) <b>Retired waiter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. R.R.</b>		11. BIRTHPLACE (City and state or country) <b>Abingdon, Va.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		
13a. FATHER'S NAME <b>Frank Hegg</b>			13b. MOTHER'S MAIDEN NAME <b>Carrie Anderson</b>			14. NAME OF HUSBAND OR WIFE <b>Geraldine Hegg</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>MI 7-01-7932</b>		17. INFORMANT Address <b>Geraldine Hegg 535 Leeton Ave</b>				
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>Hepatic Insufficiency</b> DUE TO (b) <b>Metastatic Adenocarcinoma from</b> DUE TO (c) <b>Syphilitic Transverse Colic</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
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 type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>11:30</b> a.m. Month, Day, Year <b>3-4-1960</b>		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 <b>1-30-1960</b> to <b>3-4-1960</b> and last saw him alive on <b>3-4-1960</b> Death occurred at <b>11:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>William L. Hunt M.D.</b>				22b. ADDRESS <b>601 S. Brentwood Blvd.</b>			22c. DATE SIGNED <b>3-5-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2/9/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOCAL</b>			23d. LOCATION (City, town or county) (State) <b>Columbus Ohio</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Charles J. Gates 4107 Finney</b>				25. DATE RECD. BY LOCAL REG. <b>3-7-60</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>			

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. 1823

P. O. Address 4107 Finn

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