

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH** **=60-016704**  
**EILED VS MAY 6 1960** **2 4541** STATE FILE NUMBER

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

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS, MISSOURI</b> Length of stay in 1b <b>10 Yrs.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri.</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>2102a No. Broadway</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST LOUIS HOSP. # 1.</b>		e. INSIDE LIMITS Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>ELMER</b> Middle <b>LEE</b> Last <b>CORBETT</b>	<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>27</b> Year <b>1960</b>
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<b>5. SEX</b> Male	<b>6. COLOR OR RACE</b> White	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12/21/1908</b>	<b>9. AGE (last birthday)</b> <b>51</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Machinist</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____	<b>11. BIRTHPLACE</b> (City and state or country) <b>Black Oak, Arkansas.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
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<b>13a. FATHER'S NAME</b> <b>J. J. Corbett</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Evalena Conner</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Unknown</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	<b>16. SOCIAL SECURITY NO.</b> <b>Nil.</b>	<b>17. INFORMANT</b> Address <b>Bert Forehand, Madison, Illinois</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>420.1</b>	INTERVAL BETWEEN ONSET AND DEATH _____
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CIRRHOSIS DUE TO CHRONIC ALCOHOLISM</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N. <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE _____
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21. I attended the deceased from **4/25/60** to **4/27/60** and last saw her/him alive on **4/27/60**  
 Death occurred at **12:27AM** on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>Samuel W. Hoppe, M.D.</i>	<b>22b. ADDRESS</b> <b>1515 LAFAYETTE AVE.</b>	<b>22c. DATE SIGNED</b> <b>4/27/60</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>	<b>23b. DATE</b> <b>4-30-60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Local</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Elco, Illinois.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>APR 28 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Carl Smith, M.D.</i>
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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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John J. Harrier  
Licensed Embalmer No. 4108

P. O. Address St. Louis

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.