

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS MAY 13 1960

=60-017107

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 4585** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 Wks.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 702 Wilmington St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Clifford Middle Last Maas			4. DATE OF DEATH Month April Day 29 Year 1960		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jul. 30, 1924	9. AGE (last birthday) 35	IF UNDER 1 YEAR Months 8 Days 30 Hours Min. 	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant	10b. KIND OF BUSINESS OR INDUSTRY International Shoe	11. BIRTHPLACE (City and state or country) Fortage des Sioux, Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Leo Maas	13b. MOTHER'S MAIDEN NAME Frances Mersman	14. NAME OF HUSBAND OR WIFE Dorothy Mayernick
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 48E-2E-4096	17. INFORMANT Leo Maas, Florissant, Mo.	Address
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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) Renal failure		INTERVAL BETWEEN ONSET AND DEATH 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Diabetes mellitus	21 years
	DUE TO (c) 260x	
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"/> N- <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 _____ 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 **October 1958** to **April 29, 1960** and last saw **him** alive on **April 29, 1960**
 Death occurred at **6²⁰** a **m** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Harvey Walker, Jr. M.D.	22b. ADDRESS 462 N. Taylor Ave. St. Louis 8, Mo.	22c. DATE SIGNED April 30, 1960
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 2, 1960	23c. NAME OF CEMETERY OR CREMATORY St. Francis Cemetery
		23d. LOCATION (City, town, or county) (State) Fortage des Sioux, Mo.

24. FUNERAL DIRECTOR H.C. Dallmeyer & Sons, St. Charles, Mo.	25. DATE RECD. BY LOCAL REG. APR 30 1960	26. REGISTRAR'S SIGNATURE Neal Smith, M.D.
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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

Frank R. Quinn

Licensed Embalmer No. _____

P. O. Address _____

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