

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017959

FILED VS MAY 2 1960

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 26

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>STE. GENEVIEVE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE. GENEVIEVE</u>		Length of stay in 1b <u>80 yrs</u>	c. CITY OR TOWN <u>STE. GENEVIEVE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>409 LE COMPTE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>409 LE COMPTE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle _____ Last <u>HESTER</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1960</u>	
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/25</u>	9. AGE (last birthday) <u>95</u>	IF UNDER 1 YEAR Months _____ Days _____	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) <u>CITY COLLECTOR</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>NEW OFFENBURLAND, USA</u>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <u>CHARLES HESTER</u>	13b. MOTHER'S MAIDEN NAME <u>MARY GRITNER</u>	14. NAME OF HUSBAND OR WIFE <u>IDA MAY</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>494-38-5447</u>	17. INFORMANT <u>Charles Hester</u> <u>7212 St Andrew Rd. St Louis Mo</u>	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:		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>		
DUE TO (c) _____		

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
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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 April 2, 1959 to April 25, 1960 and last saw ^{her} him alive on April 20, 1960
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>RL Lansing M.D.</u> (Degree or title)	22b. ADDRESS <u>St. Genevieve Mo.</u>	22c. DATE SIGNED <u>4/25/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALLE SPRING</u>	23d. LOCATION (City, town, or county) (State) <u>STE. GENEVIEVE MO</u>
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24. FUNERAL DIRECTOR <u>L. C. Baker</u> ADDRESS <u>St. Genevieve Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4/26/60</u>	26. REGISTRAR'S SIGNATURE <u>Louise Baker</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Adrian J. Heller

Licensed Embalmer No. 4240

P. O. Address Ste Genevieve

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.