

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020592

FILED VS MAY 17 1960

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 182

| | | | |
|------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Francois | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY City of St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township | | Length of stay in 1b 1Yr.; 3M; 13days | 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 State Hospital No. 4 | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 6175 Kingsbury Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | |
|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle F. Last NERIN | 4. DATE OF DEATH Month April Day 30 , Year 1960 |
|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|

| | | | | | | |
|-----------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------|--------------------------------------------|------------------------------------------|
| 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 July 27, 1884 | 9. AGE (last birthday) 75 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|-----------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------|--------------------------------------------|------------------------------------------|

| | | | |
|----------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------|----------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Cincinnati, Ohio | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
|----------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------|----------------------------------------------|

| | | |
|-----------------------------------------|---------------------------------------------------|------------------------------------------------------|
| 13a. FATHER'S NAME John Nerin | 13b. MOTHER'S MAIDEN NAME Ellen O'Keefe | 14. NAME OF HUSBAND OR WIFE Corinne Rodier |
|-----------------------------------------|---------------------------------------------------|------------------------------------------------------|

| | | |
|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------|
| 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. 310-01-0876 | 17. INFORMANT Address Records, State Hospital No. 4, Farmington, Mo. |
|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------|

| | | |
|----------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------|
| 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) Hemorrhage- acute massive, Bronchial - ? Esophageal | | 5 min. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) apoplexy | |
| | DUE TO (c) Generalized arteriosclerosis | Chronic |

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic brain syndrome associated with intoxication, alcohol, with behavioral reaction. | 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 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 June 9, 1958 , to April 30, 1960 and last saw <input checked="" type="checkbox"/> him <input type="checkbox"/> her live on April 30, 1960 Death occurred at 6:25 P. M. on the date stated above, and to the best of my knowledge, from the causes stated. | | |
| 22a. SIGNATURE (Degree or title) <i>[Signature]</i> | 22b. ADDRESS State Hospital No. 4 Farmington, Missouri | 22c. DATE SIGNED 4-30-60 |

| | | | |
|------------------------------------------------------------|---------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE May 3, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
|------------------------------------------------------------|---------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------|

| | | | |
|--------------------------------------------------------------------|----------------------------------|------------------------------------------------------|-------------------------------------------------|
| 24. FUNERAL DIRECTOR Kriegshauser's West, 9450 Olive Bl. | ADDRESS St. Louis, Mo. | 25. DATE RECD. BY LOCAL REG. Apr. 30, 1960 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
|--------------------------------------------------------------------|----------------------------------|------------------------------------------------------|-------------------------------------------------|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS MAY 19 1960

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 Paul K. Deegal

Licensed Embalmer No. 4120

P. O. Address Fernington

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.