

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-020913**

**FILED VS MAY 23 1960**

**318**

**1003**

**4708**

STATE FILE NUMBER

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

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u> Length of stay in 1b <u>D.O.A.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DEACONESS HOSP</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST LOUIS</u> c. CITY OR TOWN <u>Glendale</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>925 Nancy Carroll Lane</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>EDWARD</u> Middle <u>TYLER</u> Last <u>FELTS</u>			<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>1</u> Year <u>1960</u>				
<b>5. SEX</b> <u>M.</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-8-1906</u>	<b>9. AGE</b> (last birthday) <u>53</u>	<b>IF UNDER 1 YEAR</b> Months <u>9</u> Days <u>23</u>	<b>IF UNDER 24 HR</b> Hours <u>23</u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RADIO K.M.O.X. MAPLEWOOD</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Mo</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>EDWARD SEARLES FELTS</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>ALLIE RIVERS</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>FRANCES E CARTER FELTS</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <u>243-09-5875</u>		<b>17. INFORMANT</b> Address <u>915 Nancy Carroll Lane</u> <u>Frances E Felts</u>				<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) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u>420.1</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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			
<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.)					
<b>20c. TIME OF INJURY</b> Hour <u></u> a.m. <u></u> p.m. Month, Day, Year <u></u>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <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>		<b>COUNTY</b>		<b>STATE</b>	
<b>21. I attended the deceased from</b> <u>April 23, 1960</u> <b>to</b> <u>May 1, 1960</u> <b>and last saw</b> <u>him</u> <b>alive on</b> <u>April 26, 1960</u> Death occurred at <u>2:25 p.</u> <b>m</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>James B Jones M.D.</u>			<b>22b. ADDRESS</b> <u>9313 Manchester Road Rock Hill 19, Mo.</u>		<b>22c. DATE SIGNED</b> <u>5-2-60</u>		
<b>23a. MANNER OF CREMATION, BURIAL, etc.</b> (Specify) <u>CREMATION</u>	<b>23b. DATE</b> <u>5-4-1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>OAK GROVE CREMATORY</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>St Louis County Mo</u>			
<b>24. FUNERAL DIRECTOR</b> <u>MITTELBERG</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>MAY 4 1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Carl Smith, M.D.</u>		

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 Flower Stahl

Licensed Embalmer No. 4596

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.