

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021423

SL 2269 FILED VS JUN 9 1960

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5577

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND, ST LOUIS MO.		Length of stay in 1b 48 DAYS		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 VETS. ADMIN. HOSPT.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2124 CLEVELAND PL.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle B. Last RENNE			4. DATE OF DEATH Month MAY Day 30 Year 1960					
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/9/92	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10b. KIND OF BUSINESS OR INDUSTRY NORWALK, IOWA		11. BIRTHPLACE (City and state or country) U.S.A.		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME BERNARD RENNE			13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE -----			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I			16. SOCIAL SECURITY NO.		17. INFORMANT MARY CARTALL, ST. LOUIS, MO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT LUNG							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) FRACTURE OF RIGHT HIP							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 checked="" 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.) FELL THREE OR FOUR STEPS OFF FRONT PORCH						
20c. TIME OF INJURY Hour: _____ a.m. _____ p.m. Month: APRIL Day: _____ Year: '60	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) about home		20f. CITY, TOWN, OR LOCATION 2124 CLEVELAND PL., ST. LOUIS, MO.		COUNTY STATE		
21. I attended the deceased from 4/12/60 to 5/30/60 and last saw him alive on 5/30/60				Death occurred at 7:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) William H. Hoshorn M.D.			22b. ADDRESS VAH, ST. LOUIS, MO.			22c. DATE SIGNED 5/30/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 2 1960	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City, town, or county) Gravois Rd. Mo				
FUNERAL DIRECTOR Frederick Bus			ADDRESS 6409 Gravois Ave		25. DATE RECD. BY LOCAL REG. MAY 31 1960		REGISTRAR'S SIGNATURE Carl Smith, M.D.	

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

Hector J. Lee Jr.

Licensed Embalmer No. 4800

P. O. Address Richwood 22

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.