

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021672

FILED VS MAY 25 1960

318

1003

5146

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
5. SEX			8. DATE OF BIRTH		
6. COLOR OR RACE			9. AGE (last birthday)		
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and state or country)		
10c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			12. CITIZEN OF WHAT COUNTRY		

13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		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)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	

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)		
DUE TO (b)		
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.

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		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 <u>May 9 1960</u> to <u>May 12, 60</u> and last saw <u>her</u> alive on <u>May 12, 1960</u>			
Death occurred at <u>7:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22. SIGNATURE (Name or title)		22b. ADDRESS		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR		ADDRESS		25. DATE RECD. BY LOCAL REG.	
26. REGISTRAR'S SIGNATURE		27. LOCATION (City, town, or county)		(State)	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjc

AUG 28 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 Robert M. Mur

Licensed Embalmer No. 3749

P. O. Address St Louis

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