

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JUL 1 1960
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318 Primary Registration District No. 1003

Registrar's No. 6205

-60-024430
 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4145 Laclede Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CURRY Middle M. Last DANIEL			4. DATE OF DEATH Month JUNE Day 16 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 1-8-1904	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Barnes Hospital		11. BIRTHPLACE (City and state or country) Union, Arkansas		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Thomas Asa Daniel			13b. MOTHER'S MAIDEN NAME Annette Bodkin		14. NAME OF HUSBAND OR WIFE Billie Daniel			
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. unknown		17. INFORMANT Address Lillie Daniel 4145 Laclede Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION						INTERVAL BETWEEN ONSET AND DEATH FEW HOURS		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE						UNKNOWN		
DUE TO (c) _____ 420.0								
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			
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 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 SEPT. 20, 1955 , to JUNE 16, 1960 and last saw her/him alive on MARCH 21, 1960 Death occurred at 7:40 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>C. J. Demillion, M.D.</i> M.D.				22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 6/16/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 1960	23c. NAME OF CEMETERY OR CREMATORY Maynard Cemetery		23d. LOCATION (City, town, or county) Pocahontas Arkansas				
24. FUNERAL DIRECTOR Gentry R Politte Festus Mo.			25. DATE RECD. BY LOCAL REG. JUN 17 1960		26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

W. J. E.

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 Gentry R. Polk

Licensed Embalmer No. 348

P. O. Address Felton, N.C.

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.