

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 20 1960

-60-025308

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1725

ENDED

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Louis				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Berkeley		Length of stay in 1b 1 yr	c. CITY OR TOWN Berkeley Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hubbarrtt Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9732 Natural Bridge Rd Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Cartan Last Cartan			4. DATE OF DEATH June 1 1960 Month Day Year			
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 11/1/1868	9. AGE (last birthday) 91	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 carpenter		10b. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (City and state or country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Robert Cartan		13b. MOTHER'S MAIDEN NAME do not know		14. NAME OF HUSBAND OR WIFE Elizabeth		
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. None		17. INFORMANT Address Mrs WM Iseemann 8867 Kathlyn Dr		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> DUE TO (b) <u>Chr. Papillitis</u> <u>3 mo</u> DUE TO (c) <u>arterio sclerosis</u> <u>11 mo</u> 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 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 <u>6/26/59</u> to <u>6/1/60</u> and last saw ^{him} <u>June 1, 1960</u> Death occurred at <u>7 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>M. P. Seike MD</u>			22b. ADDRESS <u>9335 Page Blvd St Louis, Mo.</u>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6/3/60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St Louis MO	
24. FUNERAL DIRECTOR ADDRESS Ortmann F Home 9222 Lackland Overland Mo			25. DATE RECD. BY LOCAL REG. 6-2-60		26. REGISTRAR'S SIGNATURE <u>Johab. Murphy 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 Al C. Outmann

Licensed Embalmer No. 3478

P. O. Address _____

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.