

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-028194

FILED VS AUG 8 1960

318

1003

7605

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Missouri		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		Length of stay in 1b 60 yrs.	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 Firmin Desloge Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 230 No Boyle Ave Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Roy Middle J. Last Carper			4. DATE OF DEATH Month July Day 29 Year 1960			
5. SEX M.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/18/90	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Paint	11. BIRTHPLACE (City and state or country) Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.		

13a. FATHER'S NAME John Carper		13b. MOTHER'S MAIDEN NAME Safrona Westbrook		14. NAME OF HUSBAND OR WIFE Agnes Carper	
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. 368-12-9205		17. INFORMANT Address Mrs. Agnes Carper 230 No. Boyle	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE WITH ACUTE PULMONARY CONGESTION OF LUNGS & LIVER AND CONGESTIVE FAILURE			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) MASSIVE GASTRIC HEMORRHAGE DUE TO MULTIPLE ULCERS	5 Days	
	DUE TO (c) STATUS POST OPERATIVE VOLVULUS OF SMALL BOWEL	6 Days	
	STATUS POST OP. BIL. NOCK DISSECTION CO. OF LARYNX	3 Years	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Clinical Evidence of Hemolytic Jaundice			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.) 161X	
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 **July 22, 1960** to **July 29, 1960** and last saw her alive on **July 29, 1960**
Death occurred at **11:45 PM 7/29/60** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Walter Walter Kowalski, M.D.	22b. ADDRESS 1325 So Lindell Blvd. No 7/31/60	DATE SIGNED 7/31/60
---	---	-------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/2/1960	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
--	------------------------------	--	---

24. FUNERAL DIRECTOR Arthur J. Donnelly	ADDRESS 3840 Lindell Bl	25. DATE RECD. BY LOCAL REG. AUG 1 1960	26. REGISTRAR'S SIGNATURE Roan 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



Licensed Embalmer No. 4699

P. O. Address 384 [unclear]

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.