

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028480

FILED VS JUL 19 1960

318

1003

6597

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) a. STATE <u>Mo</u> b. COUNTY <u>ST LOUIS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Length of stay in 1b _____		c. CITY OR TOWN <u>WEBSTER GROVES 19</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST JOHN'S HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>856 NEWPORT AVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>AUGUSTINE</u> Last <u>JENNINGS</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-1869</u>	9. AGE (last birthday) <u>91-0-24</u>	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) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SERVICE Co</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>ROBERT BYRN JENNINGS</u>			13b. MOTHER'S MAIDEN NAME <u>ALICE E STEWART</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel Ora Hughes Jennings</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, (Unknown)) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>488-18-8917A</u>		17. INFORMANT Address <u>Mrs Mabel O Jennings 856 Newport Ave 19</u>				
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>Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Art. Sclerotic Coronary Thrombosis</u> DUE TO (c) <u>420.1</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</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"/> N. <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 <u>6-14-60</u> to <u>6-27-60</u> and last saw him alive on <u>6-27-60</u> Death occurred at <u>1:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Carl J. Revo M.D.</u>				22b. ADDRESS <u>W. King highway</u>		22c. DATE SIGNED <u>6-28-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-30-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION Cem</u>		23d. LOCATION (City, town, or county) (State) <u>ST LOUIS Co 23 Mo</u>				
24. FUNERAL DIRECTOR <u>MITTELBERG</u>				ADDRESS <u>WEBSTER GROVES Mo</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 29 1960</u>	26. REGISTRARS SIGNATURE <u>Loan Smith, 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

Harry E. Monroe

Licensed Embalmer No. 14495

P. O. Address St. Louis, Mo.

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.