

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS JUL 22 1960**

**-60-028483**

**7051**

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

DED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>			Length of stay in 1b <b>3 DAYS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5207 SUTHERLAND</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MATHEW</b> Middle <b>J.</b> Last <b>JOHN</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>12,</b> Year <b>1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-2-1890</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>MATHEW JOHN</b>			13b. MOTHER'S MAIDEN NAME <b>JOHANNA GODRON</b>			14. NAME OF HUSBAND OR WIFE <b>SOPHIA JOHN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>YES WW #1</b>			16. SOCIAL SECURITY NO. <b>492-10-3632</b>		17. INFORMANT <b>SOPHIA JOHN, 5707 SUTHERLAND</b>		
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) <b>Occlusion of basilar artery</b>							
DUE TO (b) <b>Cerebral arteriosclerosis</b>							
DUE TO (c) <b>332x</b>							
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 checked="" 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 <b>7/10/60</b> to <b>7/12/60</b> and last saw her alive on <b>7/12/60</b> Death occurred at <b>6:20 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Lucey Jane King, M.D.</b>			22b. ADDRESS <b>1515 LAFAYETTE AVE</b>			22c. DATE SIGNED <b>7/13/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7-16-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW ST. MARCUS ST. LOUIS COUNTY, MO</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <b>JOHN L. ZIEGENHEIN, 7027 GRAVOLS</b>			25. DATE RECD. BY LOCAL REG. <b>JUL 14 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>		

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 Donald Bering

Licensed Embalmer No. 486

P. O. Address H. Paris

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.