

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028886

FILED VS AUG 4 1960

318

1003

7138

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>Missouri</u> COUNTY									
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>St Louis</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>Enroute City Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1214 Geyer Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>(Jewell)</u> Last <u>Turnbull</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1960</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/21/97</u>		9. AGE (last birthday) <u>63</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>Waitress</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Cafeteria</u>		11. BIRTHPLACE (City and state or country) <u>St Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>						
13a. FATHER'S NAME <u>Frank Zimmerman</u>				13b. MOTHER'S MAIDEN NAME <u>Mary Hartmann</u>				14. NAME OF HUSBAND OR WIFE <u>John (Deceased)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Leapoint 3611 Osceola Street</u>							
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) <u>CORONARY OCCLUSION</u>										<u>5 MIN</u>			
DUE TO (b) <u>MITRAL STENOSIS</u>										<u>5 YEAR</u>			
DUE TO (c) <u>410x</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 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 _____ s.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>JAN 12 1959</u> to <u>JULY 15 1960</u> and last saw her <u>alive</u> on <u>JULY 15 1960</u> Death occurred at <u>10:30 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>W. J. Dash D.O.</u>					22b. ADDRESS <u>1829 S 18th St</u>					22c. DATE SIGNED <u>7-16-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7/18/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City, town, or county) <u>Lamay Missouri</u>			(State)			
24. FUNERAL DIRECTOR <u>Moydell Funeral Home 1926 Allen</u>					25. DATE RECD. BY LOCAL REG. <u>JUL 16 1960</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D. 1003</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 Halley F. Faeller Jr
Licensed Embalmer No. 4950
P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.