

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-028893
STATE FILE NUMBER

FILED VS AUG 6 1960 318 Primary Registration District No. 1003 Registrar's No. 7439

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b		c. CITY OR TOWN Farmington
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Glennon Memorial Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Farmington
3. NAME OF DECEASED (Type or print) First Middle Last William Bryan Vince			4. DATE OF DEATH Month Day Year July 21 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/21/1958	9. AGE (last birthday) 1	IF UNDER 1 YEAR Months Days Hours Min. 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Francois Co., Mo.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Vernon Vince		13b. MOTHER'S MAIDEN NAME Mary Burnett		13c. NAME OF HUSBAND OR WIFE None	
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 Vernon Vince, Farmington, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Congenital heart disease DUE TO (c) (Ventricular Septal defect - post-operation) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) 754.2					INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. 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 7-20-60 to 7-22-60 and last saw ^{her} him alive on 7-22-60 Death occurred at 1:25 P on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Vallee J. Willman M.D.			22b. ADDRESS 1325 S. Grand		22c. DATE SIGNED 7-22-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-25-60	23c. NAME OF CEMETERY OR CREMATORY Hill View Memorial Gardens		23d. LOCATION (City, town, or county) Farmington, Missouri	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.,		25. DATE RECD. BY LOCAL REG. JUL 26 1960		26. REGISTRAR'S SIGNATURE Loal Smith, M.D.	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

2270

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 Henry Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis

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.