

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-029188

FILED JUL 22 1960

317

Registration District No. 59- Registrar's No. 2153

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>ST. LOUIS</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>VALLEY PARK</b>		Length of stay in lb <b>3 months</b>		c. CITY OR TOWN <b>WARSON WOODS, MO.</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>MOLL NURSING HOME</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1660 DEARBORN DR.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HERBERT ANGLES LUCY</b>				4. DATE OF DEATH Month Day Year <b>JULY 18, 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>9/26/1892</b>	9. AGE (last birthday) <b>67</b>	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) <b>SALESMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>FOODSTUFFS</b>		11. BIRTHPLACE (City and state or country) <b>BRUNOT, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>CICERO HALL LUCY</b>			13b. MOTHER'S MAIDEN NAME <b>IDA ELIZABETH SULLIVAN</b>			14. NAME OF HUSBAND OR WIFE <b>BLANCHE RAMSEY LUCY</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>492-07-2819</b>		17. INFORMANT Address <b>MRS. BLANCHE LUCY, 1660 DEARBORN</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 yrs.</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 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>4-15-60</b> to <b>4-18-60</b> and last saw him alive on <b>4/17/60</b> Death occurred at <b>6:50 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (I agree or title) <i>[Signature]</i>				22b. ADDRESS <b>Kirkwood 21. MO</b>			22c. DATE SIGNED <b>7/19/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7/20/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEMETERY</b>		23d. LOCATION (City, town, or county) <b>KIRKWOOD, MO.</b>			
24. FUNERAL DIRECTOR <b>PARKER-ALDRICH, WEBSTER GROVES, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>7-19-60</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Frederic W. Bauer

Licensed Embalmer No. 460

P. O. Address St. Charles

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.