URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ILED VS AUG 8 1960

-60-029235
STATE FILE NUMBER

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Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2192

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Ballwin
Length of stay in 1b: 1 mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: New Ballwin and Hi 100
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: St. Louis
c. CITY OR TOWN: Ballwin
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 20 Highview
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Donald Middle: Wayne Last: Lester
4. DATE OF DEATH: Month Day Year: 7/22/60
5. SEX: M
6. COLOR OR RACE: W
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: June 1,
9. AGE (last birthday)
IF UNDER 1 YEAR: Months 1 Days 22
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ———
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (City and state or country): St. Louis
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Leroy Lester
13b. MOTHER'S MAIDEN NAME: Mildred Allen
14. NAME OF HUSBAND OR WIFE: ———
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Leroy Lester, Address: Ballwin, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 ____ to ____ and last saw her/him alive on ____
Death occurred at 12:05P m on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE (Degree or title): John C. Murphy M.D.
John C. Murphy MD Asst. Health Commissioner
22b. ADDRESS: 801 S. Brentwood Clayton, Mo.
22c. DATE SIGNED: 7-29-60
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 7/23/60
23c. NAME OF CEMETERY OR CREMATORY: LOCAL
23d. LOCATION (City, town, or county) (State): Charleston, Mo.
24. FUNERAL DIRECTOR: Schrader Funeral Home, ADDRESS: Ballwin, Mo.
25. DATE RECD. BY LOCAL REG.: 7-23-60
26. REGISTRAR'S SIGNATURE: John C. Murphy Md.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed Richard M. Fo

Signature of Student Embalmer

Licensed Embalmer No. 4584

P. O. Address Baltimo

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