

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-031827

FILED 13 AUG 17 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7789** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION residence 4919 McPherson		d. STREET ADDRESS (If outside, give location) 4919 McPherson Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First WATSON Middle POMEROY Last AULL			4. DATE OF DEATH Month August Day 5 Year 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 May 30, 1886	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY box manufacturing		11. BIRTHPLACE (City and state or country) Lexington, Missouri		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME James Aull		13b. MOTHER'S MAIDEN NAME Hetty Grant		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW #1		16. SOCIAL SECURITY NO.		17. INFORMANT James Aull, 19 Algonquin Estates R Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cerebral thrombosis** INTERVAL BETWEEN ONSET AND DEATH **1 day**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)
DUE TO (b) **Cerebral arteriosclerosis**

DUE TO (c) **332x**

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 <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.)
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20c. TIME OF INJURY Hour a.m. p.m.	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
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21. I attended the deceased from **March 1958** to **present** and last saw her alive on **Aug. 4, 1960**
Death occurred at **6 AM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert C. Fitzgerald (Degree or title) MD	22b. ADDRESS 14 Forsyth Walk, Clayton 5, Mo.	22c. DATE SIGNED 8-6-60 (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 8-8-1960	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri
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24. FUNERAL DIRECTOR C. R. Lupton & Sons-7233 Delmar	25. DATE RECD. BY LOCAL REG. AUG 6 1960	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

October 11 a.m. last
week 1:30 P.M.

Mrs. Peasey - 4304 N. Skinker,
W. at 3:00 P.M. lat.

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 Arnold W. Schoe

Licensed Embalmer No. 386

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.