

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. SEP 2 1960 318

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8102

-60-032225

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 MISSOURI b. COUNTY St. Louis								
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b		c. CITY OR TOWN University City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 7301 Westmoreland			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Harold H. Giger						4. DATE OF DEATH Month Day Year August 16, 1960						
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-11-1895		9. AGE (last birthday) 65				
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) Broker, Res. Mgr. Cruttenden Podesta and Co.			10b. KIND OF BUSINESS OR INDUSTRY Elmdale Kansas		11. BIRTHPLACE (City and state or country) U.S.A.			
12. CITIZEN OF WHAT COUNTRY			13a. FATHER'S NAME Harvey Milton Giger			13b. MOTHER'S MAIDEN NAME Cornelia Loose			14. NAME OF HUSBAND OR WIFE Emma May Giger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.II				16. SOCIAL SECURITY NO. 493-05-7572			17. INFORMANT Address Emma May Giger 7301 Westmoreland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease with Mitral stenosis and myocardial calcare								INTERVAL BETWEEN ONSET AND DEATH 40 yrs				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Congestion								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 checked="" type="checkbox"/> NO <input 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 8/8/60 to 8/16/60 and last saw her alive on 8/15/60 Death occurred at 6:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Decease or wife) K. L. McCoy MD						22b. ADDRESS 3720 Washington St. St. Louis 8, Mo.			22c. DATE SIGNED 8/17/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-18-1960		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery			23d. LOCATION (City, town, or county) (State) St. Louis County Missouri.					
24. FUNERAL DIRECTOR C.R. Lupton and Sons 7233 Delmar Blvd.				ADDRESS		25. DATE RECD. BY LOCAL REG. AUG 17 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 21 1961

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 C. Lawrence H. M.

Licensed Embalmer No. 407
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.