

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital DOA			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4906 A Nottingham		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Megal				4. DATE OF DEATH Month Day Year 7/22/60				
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/4/1873	9. AGE (last birthday) 86	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) Retired Mailer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Lena Megal			
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.		17. INFORMANT Address Dana Megal, 4906A Nottingham				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subdural Hemorrhage</i> DUE TO (b) <i>Ruptured Spleen</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS (Disease condition given in PART I (a)) <i>Chipped teeth, struck by transport</i>				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"/>	20. TIME OF INJURY Hour Month, Day, Year 4:10 p.m. 7/22/60	21. OCCIDENT SUICIDE MURDER <i>Accident</i> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Street</i>	23. CITY, TOWN, OR LOCATION <i>St. Louis Mo</i>	24. STATE			
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Joseph M. Ziegenhein</i>			22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>7-24-60</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>7/26/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New St. Marcus</i>		23d. LOCATION (City, town, or county) <i>St. Louis County</i>	23e. STATE <i>Mo.</i>			
24. FUNERAL DIRECTOR <i>John L. Ziegenhein & Sons, 7027 Gravois</i>			25. DATE RECD. BY LOCAL REG. <i>JUL 25 1960</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</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 by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed E. A. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gra

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