

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 2 1960

-60-032716

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7747 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b	c. CITY OR TOWN <u>AFFTON</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. ANTHONY HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>29 GRANTWOOD LANE</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>ROBERT J. PAULLUS</u> First <u>Robert</u> Middle <u>Paulus</u> Last			4. DATE OF DEATH <u>AUG 3 1960</u> Month Day Year			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 8. 1901</u>	9. AGE (last birthday) <u>58</u>	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) <u>BLDG CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>
13a. FATHER'S NAME <u>ROBERT PAULUS</u>		13b. MOTHER'S MAIDEN NAME <u>NETTIE FRANK</u>		14. NAME OF HUSBAND OR WIFE <u>VIOLA PAULUS</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR II</u>	16. SOCIAL SECURITY NO. <u>499-36-8809</u>	17. INFORMANT <u>VIOLA PAULUS</u>	Address <u>29 GRANTWOOD LANE</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>4yr 4yr</u>
IMMEDIATE CAUSE (a) <u>DISEASE CORONARY ARTERIES</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIO SCLEROSIS</u>		
DUE TO (c) <u>4201</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CEREBRAL THROMBOSIS & EMBOLISM</u>		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	
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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. Month, Day, Year
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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 8/15/60 to 8/3/60 and last saw him alive on 8/3/60
Death occurred at 7:20 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert P Smith M.D.</u>	(Degree or title)	22b. ADDRESS <u>5203 Cluff Ave</u>	22c. DATE SIGNED <u>8/5/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>AUG 8. 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO.</u>
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24. FUNERAL DIRECTOR <u>Thomas Kutas</u>	ADDRESS <u>2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 5. 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

4-12-5200

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 *James O. Bell*

Licensed Embalmer No. 4347
P. O. Address 2906 St.

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.