

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032742

FILED VS. SEP 2 1960 318 Primary Registration District No. 1003 Registrar's No. 8443 STATE FILE NUMBER

DED

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 Mo.		Length of stay in 1b All Life	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 Jewish Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 237 N. Euclid Ave.	
3. NAME OF DECEASED (Type or print) First Albert Middle J. Last Poulin			4. DATE OF DEATH Month 8 Day 26 Year 1960		
5. SEX M.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/11/60	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (City and state or country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Remy Poulin		13b. MOTHER'S MAIDEN NAME Onesime Benjain		14. NAME OF HUSBAND OR WIFE Edith	
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 Edith Poulin 237 N. Euclid		

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

IMMEDIATE CAUSE (a) *acute pancreatitis*

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) *acute cholecystitis & cholelithiasis*

DUE TO (c) *584x*

INTERVAL BETWEEN ONSET AND DEATH
6 days
6 days

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 *8/25/60* to *8/26/60* and last saw ^{her}him alive on *8/26/60*
Death occurred at *5:10 PM* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
David D. Munnich, M.D.

22b. ADDRESS
100 W. Euclid St. Louis Mo

22c. DATE SIGNED
8-27-60

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE
8/29/60

23c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery

23d. LOCATION (City, town, or county) (State)
St. Louis Mo

24. FUNERAL DIRECTOR ADDRESS
Arthur J. Donnelly 3840 Lindell Blvd.

25. DATE RECD. BY LOCAL REG.
AUG 29 1960

26. REGISTRAR'S SIGNATURE
Earl Smith, M.D.

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 469
P. O. Address 384

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.