

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED SEP 7 1960

-60-033340
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2492

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		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>Pine Lawn</u>		Length of stay in 1b <u>2 yrs.</u>	c. CITY OR TOWN <u>Pine Lawn</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Res. 3917 Beachwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>3917 Beachwood</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>ARCHIBALD (ARCHIE) ALONZO MIKEL</u> First Middle Last			4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1960</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>9/9/1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stove Moulder</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Furnace</u>	11. BIRTHPLACE (City and state or country) <u>Maryland Heights, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert L. Mikel</u>	13b. MOTHER'S MAIDEN NAME <u>Flora Crawford</u>	14. NAME OF HUSBAND OR WIFE <u>Emily L. Mikel</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>488-03-3657</u>	17. INFORMANT <u>Emily Mikel-3917 Beachwood, Pine Lawn, Mo.</u>	Address
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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: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure 10 day</u> DUE TO (b) <u>Arteriosclerotic Heart Disease 5 yrs</u> DUE TO (c) <u>Generalized Arteriosclerosis 5-10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Terminal Broncho pneumonia</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

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 <u>10</u> Month, Day, Year <u>Aug 21, 1960</u> a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 May 4, 1959 to Aug 21, 1960 and last saw him alive on August 20, 1960
Death occurred at August 24, 1960 12:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Leonard D. Piccine M.D.</u>	22b. ADDRESS <u>6303 Natural Bridge Mo.</u>	22c. DATE SIGNED <u>8-22-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/24/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Missouri</u>
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24. FUNERAL DIRECTOR <u>Baumann Bros. 2504 Woodson, Overland</u>	25. DATE RECD. BY LOCAL REG. <u>8-22-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Piccione
6200 Nat. Bridge
EV5-9393

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

David C. Gibson

Licensed Embalmer No. 3450

P. O. Address Overland

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