

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036060

FILED VS OCT 14 1960

318

Primary Registration District No. 1003

Registrar's No. 9643

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in ¹ / _{lb} <u>1 DAY</u>		c. CITY OR TOWN <u>ST. LOUIS</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>DEACONESS HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5220 WATERMAN</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>LARRY</u> Middle <u>WILLIAM</u> Last <u>DRINEN</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>2</u> Year <u>1960</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 1 1960</u>	9. AGE (last birthday) <u>1 DAY</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u>		IF UNDER 24 HR Hours <u>2</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>DEACONESS HOSP. ST. LOUIS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>LAWRENCE DRINEN</u>			13b. MOTHER'S MAIDEN NAME <u>BETTY LOU MONTGOMERY</u>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>LAWRENCE DRINEN</u>			Address <u>5220 WATERMAN ST. LOUIS MO</u>	
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>Atelectasis, Pulmonary, Bact.</u> DUE TO (b) _____ DUE TO (c) <u>762.0</u> 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 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. <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 <u>---</u> 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 <u>1 Oct 60</u> to <u>2 Oct 60</u> and last saw him ^{from} alive on <u>2 Oct 60</u> . Death occurred at <u>4:15 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Joe E Hall M.D.</u> (Degree or title)				22b. ADDRESS <u>35 N. Central Ave (5)</u>			22c. DATE SIGNED <u>3 Oct 60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>OCT. 3 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WARE</u>		23d. LOCATION (City, town, or county) <u>WARE Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>DIETRICH FUNERAL HOME</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>OCT 1 1960</u>		26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>			

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 Donnell B. Dietrich

Licensed Embalmer No. 4104

P. O. Address Deleto Md

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.