

OPERATIONS FOR PUBLIC RECORDS
 DOCUMENTS
 MEDICAL CERTIFICATION
 AFFIDAVIT OF
 Sworn (see not attached)

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY St. Louis							
b. CITY (If outside corporate limits, give TOWNSHIP only) 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 Turner DeLooge Hosp			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 7616 Virginia		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First JAMES Middle FERNANDEZ Last FERNANDEZ				4. DATE OF DEATH Month Sept Day 15 Year 1960							
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/8/1910		9. AGE (last birthday) 50		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTH PLACE (City and state or country) Spain		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME CELESTINO Fernandez				13b. MOTHER'S MAIDEN NAME EDE Menendez				14. NAME OF HUSBAND OR WIFE Lillie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Lillie Fernandez 7616 Virginia		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Surgical shock caused by removing the left lung Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 523.0 DUE TO (c)										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) Following operation (removal of lung) at Jefferson DeLooge Hospital on September 15th 1960							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 checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART III, item 18.) (removal of lung) at Jefferson DeLooge Hospital on September 15th 1960							
20c. TIME OF INJURY Hour 9:15 a.m. 15th Month 15th Day, Year 1960		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.) Hosp			20f. CITY, TOWN, OR LOCATION St. Louis MO		STATE	
21. I attended the deceased from 303 P. 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 Patrick F. Taylor Coroner				22b. ADDRESS 1300 Clark				22c. DATE SIGNED 9.17.60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Sept 19 1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope		23d. LOCATION (City, town, or county) Lemay MO		STATE			
24. FUNERAL DIRECTOR JOS. P. FENDLER JR. 7123 MICHIGAN				25. DATE RECD. BY LOCAL REG. SEP 17 1960		26. REGISTRAR'S SIGNATURE Road Smith. M.D.					

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 *Alene Kochow*

Licensed Embalmer No. 3093

P. O. Address 7178 Me

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.