

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP.#1.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>904 N. 15th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ENG</b> Last <b>YIN</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>23</b> Year <b>1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Yellow</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11/25/1910</b>	9. AGE (last birthday) <b>49</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Drill Press Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>San Francisco, California</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Unavailable</b>			13b. MOTHER'S MAIDEN NAME <b>Unavailable</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW II</b>			16. SOCIAL SECURITY NO. <b>493-20-7291</b>		17. INFORMANT Address <b>Joe Jone, 2549 Tyrell</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALNUTRITION, CACHEXIA</b> DUE TO (b) <b>WIDESPREAD ABDOMINAL METASTASES OF BLADDER-CARCINOMA</b> DUE TO (c) <b>TRANSITIONAL CELL CARCINOMA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b> <b>6 MONTHS</b> <b>6 MOS. +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PELVIC ABSCESS 1810</b>						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 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 <b>28 July 1960</b> to <b>23 Sept. 1960</b> and last saw her/him alive on <b>23 Sept. 1960</b>				Death occurred at <b>5:45</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <b>John F. Cleahan M.D.</b>				22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>			22c. DATE SIGNED <b>23 Sep 60</b>	
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9-27-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 26 1960</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>		

DOCUMENT

BY AFFIDAVIT OF funeral director

MEDICAL CERTIFICATION

**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 Melvin L. Kemp

Licensed Embalmer No. 405-2

P. O. Address St Louis

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