

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037029

FILED VS OCT 1 0 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2880

STATE FILE NUMBER

INDEXED

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>Manchester Rt 2</u>		Length of stay in lb <u>1 yr.</u>		c. CITY OR TOWN <u>Manchester</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>District Rd</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt. 2-</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print): First <u>Ida</u> Middle <u>Gene</u> Last <u>Dyer</u>			4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>60</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/21/1875</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Karni Ill.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>James Rose</u>		13b. MOTHER'S MAIDEN NAME <u>Daphine Oschin</u>	
14. NAME OF HUSBAND OR WIFE <u>unk.</u>		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>None</u>	
17. INFORMANT <u>Thelma Wiegand - as above</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>Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 yrs.</u> <u>10 yrs</u>	
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 checked="" 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.)		
20c. TIME OF INJURY Hour <u>6 A.M.</u> Month, Day, Year <u>9-30-60</u>	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>9-30-60</u> to <u>10-1-60</u> and last saw her <u>live</u> on <u>9-30-60</u> Death occurred at <u>6 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Louie C. Hyatt M.D.</u>		22b. ADDRESS <u>134 W. Adams</u>		22c. DATE SIGNED <u>10-2-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>	23b. DATE <u>10/3/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Manchester Mo.</u>	
24. FUNERAL DIRECTOR <u>Leah Fisher</u>		ADDRESS <u>Fenton Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-2-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy 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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Daniel J. M...

Licensed Embalmer No. 43

P. O. Address He Soto

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