

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis				Length of stay in lb 13 days		c. CITY OR TOWN Arnold	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 107 Elm Dr.	
3. NAME OF DECEASED (Type or print) First Otis Middle Chrisco Last Chrisco				4. DATE OF DEATH Month November Day 1 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 4/1/1906	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Paper Box Co.		11. BIRTHPLACE (City and state or country) Sinken, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Hampton Chrisco			13b. MOTHER'S MAIDEN NAME Belle Ball			14. NAME OF HUSBAND OR WIFE Hilda	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hilda Chrisco, Arnold, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma's						INTERVAL BETWEEN ONSET AND DEATH 6 months	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of Liver						6 months	
DUE TO (c) 156.1							
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 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 6:20 am a.m. p.m.	Month, Day, Year Sept 1960						
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 Sept 1960 to Nov 1, 1960 and last saw him alive on Oct 31, 1960 Death occurred at 6:20 am on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Walter W. Davis MD (Degree or title)				22b. ADDRESS 539 N. Grand			22c. DATE SIGNED 11/1/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-1-60	23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		23d. LOCATION (City, town, or county) Arnold, Mo.		(State)
24. FUNERAL DIRECTOR Heiligtag Funeral Home, Inperial, Mo.				25. DATE RECD. BY LOCAL REG. NOV 1 1960		26. REGISTRAR'S SIGNATURE Leal Smith, M.D.	

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 Eleonore H. Rene

Licensed Embalmer No. 428

P. O. Address H. Lo

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