

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		Length of stay in 1b	c. CITY OR TOWN <i>ST. LOUIS</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>5410 RHODES</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>4238 ELLENWOOD</i>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>E.</i> Middle <i>MEREDITH</i> Last <i>LAYTON SR</i>	4. DATE OF DEATH Month <i>Nov.</i> Day <i>2</i> Year <i>1960</i>
---	---

5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 21 1908</i>	9. AGE (last birthday) <i>52</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	--	-------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PAYMASTER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>GEN. AMER. LIFE INS. ST. LOUIS Mo</i>	11. BIRTHPLACE (City and state or country) <i>Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
---	---	---	--

13a. FATHER'S NAME <i>E. HERMAN LAYTON</i>	13b. MOTHER'S MAIDEN NAME <i>EDITH MOORE</i>	14. NAME OF HUSBAND OR WIFE <i>GENEVIEVE LAYTON</i>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>488-10-0320</i>	17. INFORMANT <i>Genevieve LAYTON 4238 ELLENWOOD</i>
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i>		<i>2 HOURS</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) <i>4201</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>NO</i>	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 _____ 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 *1958* to *1960* and last saw ^{her} him alive on *11/2/60*
 Death occurred at *11:45* *P* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>John A. Reineck MD</i>	22b. ADDRESS <i>4906 Southwest P.ouis</i>	22c. DATE SIGNED <i>11/4/60</i>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>NOV. 7 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>RESURRECTION CEM.</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>
---	---------------------------------	--	--

24. GENERAL DIRECTOR <i>Thomas Kutis</i>	ADDRESS <i>2906 Francis</i>	25. DATE RECD. BY LOCAL REG. <i>NOV 4 1960</i>	26. REGISTRAR'S SIGNATURE <i>Loal Smith M.D.</i>
---	--------------------------------	---	---

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

James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906

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.