

<b>1. PLACE OF DEATH</b> a. COUNTY _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY _____							
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>St. Louis Mo</u>		Length of stay in 1b _____		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (if not in hospital, give location) HOSPITAL OR INSTITUTION <u>809 N. Franklin</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>809 N. Franklin</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Arthur</u> Middle <u>Guy</u> Last <u>Strong</u>				<b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>26</u> Year <u>60</u>							
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>47</u>	<b>9. AGE (last birthday)</b> IF UNDER 1 YEAR      IF UNDER 24 HR Months      Days      Hours      Min.							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Auto</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>				
<b>13a. FATHER'S NAME</b> <u>Walter</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Walter</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Walter</u>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>Walter</u>		<b>17. INFORMANT</b> <u>W.C. Taylor</u>			Address <u>1300 Clark</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO (b) <u>Chronic Coronary Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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) <u>420.1</u>					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						
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____									
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>			
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.											
<b>22a. SIGNATURE</b> (Degree or title) <u>Joseph M. Deussen</u>				<b>22b. ADDRESS</b> <u>1300 Clark</u>				<b>22c. DATE SIGNED</b> <u>10-27-60</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>		<b>23b. DATE</b> <u>11-1-1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Matthews Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) <u>St. Louis, Missouri</u>					
<b>24. FUNERAL DIRECTOR</b> <u>Albert H. Hoppe, Inc.</u> <u>4700 Washington</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>OCT 31 1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Earl Smith, 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 by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

**NOT EMBALMED      BURIED BY CITY.**

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.