

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED IN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 REGISTRATION DISTRICT NO. 317 PRIMARY REGISTRATION DISTRICT NO. 541 REGISTRAR'S NO. 2827 STATE FILE NUMBER 60-040470

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| 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>CLAYTON</u> | | c. CITY OR TOWN <u>LEMAY</u> | |
| Length of stay in 1b <u>MINS.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COUNTY Hosp.</u> | | d. STREET ADDRESS (If outside, give location) <u>2930 LEMAY FERRY RD.</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Alphonse</u> Middle <u>W.</u> Last <u>DeMerville</u> | 4. DATE OF DEATH Month <u>Sept</u> Day <u>24</u> Year <u>1960</u> |
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| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/23/1892</u> | 9. AGE (last birthday) <u>68</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE (RETIRED)</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>(RETIRED)</u> | 11. BIRTHPLACE (City and state or country) <u>ST LOUIS, MO</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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| 13a. FATHER'S NAME <u>HARRY DEMERVILLE</u> | 13b. MOTHER'S MAIDEN NAME <u>EMMA MEYER</u> | 14. NAME OF HUSBAND OR WIFE <u>ELLA FOELSCH MERVILLE</u> |
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| 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>488-38-9336</u> | 17. INFORMANT <u>ELLA DEMERVILLE</u> Address <u>LEMAY, MO.</u> |
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| 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>Punctured wound to @ heart chamber</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 hr 45 min</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) _____ | |
| | DUE TO (c) _____ | |

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| 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 |
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| 19. WAS AUTOPSY PERFORMED? YES <input 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ |
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| 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 |
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21. I attended the deceased from Sept 24, 1960 to Sept 24, 1960 and last saw him alive on Sept 24, 1960
 Death occurred at 6:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Robert J. Vorhies M.D.</u> | 22b. ADDRESS <u>601 S. Brentwood Pl. Clayton Mo.</u> | 22c. DATE SIGNED <u>9/28/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>9-28, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>ST. TRINITY</u> | 23d. LOCATION (City, town, or county) (State) <u>LEMAY, MO.</u> |
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| 24. FUNERAL DIRECTOR <u>C. HOFFMEISTER</u> ADDRESS <u>7814 S. BROADWAY</u> | 25. DATE RCD. BY LOCAL REG. <u>9/26/60</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy, Md.</u> |
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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.

Student _____
Signature of Student Embalmer

Signed

John P. Donnelly

Licensed Embalmer No. *4494*

P. O. Address *St. Louis*

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.