

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS: NOV 17 1960

318

Primary Registration District No. 1003

Registrar's No. 10773

STATE FILE NUMBER -60-043436

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN<br>St. Louis                 |  | Length of stay in lb<br>1 hr.   | c. CITY OR TOWN<br>St. Ann   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br>Barnes Hospital |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br>3620 St. Sebastian La.<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|                                     |                |               |                  |          |              |
|-------------------------------------|----------------|---------------|------------------|----------|--------------|
| 3. NAME OF DECEASED (Type or print) |                |               | 4. DATE OF DEATH |          |              |
| First<br>HAROLD                     | Middle<br>JOHN | Last<br>CHASE | Month<br>Nov.    | Day<br>7 | Year<br>1960 |

|             |                       |   |                                |                              |                                   |                                 |
|-------------|-----------------------|---|--------------------------------|------------------------------|-----------------------------------|---------------------------------|
| 5. SEX<br>M | 6. COLOR OR RACE<br>W | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br>10-12-1904 | 9. AGE (last birthday)<br>56 | IF UNDER 1 YEAR<br>Months<br>Days | IF UNDER 24 HR<br>Hours<br>Min. |
|-------------|-----------------------|---|--------------------------------|------------------------------|-----------------------------------|---------------------------------|

|   |  |  |                                    |
|---|--|--|------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Cartographer | 10b. KIND OF BUSINESS OR INDUSTRY<br>Map Dept. | 11. BIRTHPLACE (City and state or country)<br>Peoria, Ill. | 12. CITIZEN OF WHAT COUNTRY<br>USA |
|---|--|--|------------------------------------|

|                                 |   |   |
|---------------------------------|---|---|
| 13a. FATHER'S NAME<br>Lee Chase | 13b. MOTHER'S MAIDEN NAME<br>Emma Huthoff | 14. NAME OF HUSBAND OR WIFE<br>Dorothy L. Chase |
|---------------------------------|---|---|

|   |                                 |                                   |  |
|---|---------------------------------|-----------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No None | 16. SOCIAL SECURITY NO.<br>None | 17. INFORMANT<br>Dorothy L. Chase | Address<br>St. Ann<br>3620 St. Sebastian La. |
|---|---------------------------------|-----------------------------------|--|

|  |   |                                  |
|--|---|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |   | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>  |   | 1 hr.                            |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.               | DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> | 2 yrs.                           |
|  | DUE TO (c) <u>420.0</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.<br><input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |
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|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" 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.) |
|---|---|--|

|   |                  |
|---|------------------|
| 20c. TIME OF INJURY<br>Hour<br>a.m.<br>p.m. | Month, Day, Year |
|---|------------------|

|   |  |                              |        |       |
|---|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Jan. 12, 1958 to 11-4-60 and last saw him alive on 11-4-60  
Death occurred at 9 A m on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                   |  |                                    |
|--|-------------------|--|------------------------------------|
| 22a. SIGNATURE<br><u>Herman J. Klocke M.D.</u> | (Degree or title) | 22b. ADDRESS<br><u>9616 Bachman Rd</u> | 22c. DATE SIGNED<br><u>11-8-60</u> |
|--|-------------------|--|------------------------------------|

|  |                         |  |  |         |
|--|-------------------------|--|--|---------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal | 23b. DATE<br>11-10-1960 | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Grove Cemetery | 23d. LOCATION (City, town, or county)<br>St. Louis County, Mo. | (State) |
|--|-------------------------|--|--|---------|

|   |  |  |
|---|--|--|
| 24. FUNERAL HOME<br>BRAUMANN BROS. INC. FUNERAL HOME<br>2504 WOODSON ROAD | 25. DATE RECD. BY LOCAL REG.<br>NOV 8 1960 | 26. REGISTRAR'S SIGNATURE<br><u>Loan Smith, M.D.</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 David C. [Signature]

Licensed Embalmer No. 345

P. O. Address [Signature]

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.