

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 5 Hrs.	c. CITY OR TOWN Webster Groves
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 209 Newport Ave.

3. NAME OF DECEASED (Type or print) First Middle Last OSCAR HARLAN DELLINGER			4. DATE OF DEATH Month Day Year Nov. 5, 1960		
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-9-93	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dry Cleaning		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and state or country) Catawba Co. N. Car.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Jonas Dellinger		13b. MOTHER'S MAIDEN NAME Harriet Eisenhower		14. NAME OF HUSBAND OR WIFE Alberta Dellinger	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 493-01-5410	17. INFORMANT Mrs. O. H. Dellinger, 209 Newport
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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) Status Asthmaticus c acute pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH 2 hours
DUE TO (b) Chronic Bronchial Asthma		Several years
DUE TO (c) Pulmonary Emphysema + JERSONI		years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease - 241*		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 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.)
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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
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21. I attended the deceased from 11-1-60 , to 11-5-60 and last saw her alive on 11-4-60 Death occurred at 7:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Grant L. Quinlan MD	22b. ADDRESS 7961 Bay Bend Webster Groves Mo.	22c. DATE SIGNED 11-7-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-8-60	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Parker-Aldrich, Webster Groves	25. DATE RECD. BY LOCAL REG. NOV 8 1960	26. REGISTRAR'S SIGNATURE Grant Smith, M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

10-1-1934

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 Leslie Welch

Licensed Embalmer No. 43
P. O. Address Wabster

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.