

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 3 DAYS	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 NO. GRAND AVE.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 445 PERSHING AVE.
3. NAME OF DECEASED (Type or print) First MUSE Middle Last		4. DATE OF DEATH Month 11/18/60 Day Year	

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/2/86	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER		10b. KIND OF BUSINESS OR INDUSTRY ROME, ITALY		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME JOHN P. MUSE		13b. MOTHER'S MAIDEN NAME MATTIE A. MARINELLI		14. NAME OF HUSBAND OR WIFE CATHERINE MUSE		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES	16. SOCIAL SECURITY NO. 488 05 6481	17. INFORMANT CATHERINE MUSE (WIDOW) SEE #2	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) UREMIA		
DUE TO (b) ARTERIOLONEPHROSCLEROSIS		
DUE TO (c) 446x		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) GASTROINTESTINAL HEMORRHAGE - GASTRIC ULCER - BENIGN		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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.

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 11/15/60 to 11/18/60 and last saw him alive on 11/18/60
 Death occurred at 1:45 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John R. Hogan M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 11/18/60
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23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/21/60	23c. NAME OF CEMETERY OR CREMATORY National	23d. LOCATION (City, town, or county) (State) Jefferson Barricks Mo.
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24. FUNERAL DIRECTOR Arthur J. Donnelly ADDRESS 3840 Lindell Blvd	25. DATE RECD. BY LOCAL REG. NOV 19 1960	26. REGISTRAR'S SIGNATURE Loan Smith M.D.
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Francis Orilla

Licensed Embalmer No. 35
P. O. Address 38400

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.