

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 17 1960

318

1003

60-044373
STATE FILE NUMBER

REGISTRATION DISTRICT NO. Primary Registration District No. Registrar's No.

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 1b	c. CITY OR TOWN ST. LOUIS	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL #1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 1211 So. 6th	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First TUESDAY Middle Last WEEKLY			4. DATE OF DEATH Month 11 Day 2 Year 60				
5. SEX FEMALE	6. COLOR OR RACE NEGRD	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-8-60	9. AGE (last birthday) 7	IF UNDER 1 YEAR Months 7 Days	IF UNDER 24 HR Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME EURENE WEEKLY			13b. MOTHER'S MAIDEN NAME ELIZABETH STOVALL		14. NAME OF HUSBAND OR WIFE NONE		
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. NONE		17. INFORMANT Elizabeth Weekly 1211 So. 6th St.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Meningitis**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Bronchopneumonia, rt. lung

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED?
YES NO

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour Month, Day, Year
a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree & title)
Joseph D. Quisenberry

22b. ADDRESS
1300 E. Locust

22c. DATE SIGNED
11-5-60

23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

23b. DATE
11-8-60

23c. NAME OF CEMETERY OR CREMATORY
OAKDALE CEMETERY

23d. LOCATION (City, town, or county) (State)
LEMAY COUNTY, MO.

24. FUNERAL DIRECTOR ADDRESS
MCCAIN 2812 CASS

25. DATE RECD. BY LOCAL REG.
NOV 5 1960

26. REGISTRAR'S SIGNATURE
Loan Smith M.D.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1971-27-6-16

STATE BOARD OF HEALTH

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wallace R. Williams

Licensed Embalmer No. 4926
P. O. Address 5135 Lotus

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.