

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044599

FILED VS DEC 12 1960

317

Primary Registration District No.

547

Registrar's No.

3499

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		Length of stay in 1b 3 Weeks	c. CITY OR TOWN St. Charles Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1116 Madison Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last DR. JOSEPH M JENKINS			4. DATE OF DEATH Month Day Year November 29, 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 5/5/1882
9. AGE (last birthday) 78		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Private Practice	11. BIRTHPLACE (City and state or country) Uniontown, Kentucky
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Dr. John Jenkins	
13b. MOTHER'S MAIDEN NAME Alicia Payne		14. NAME OF HUSBAND OR WIFE Rose Jenkins	
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 Address Rose Jenkins 1116 Madison, St. Charles Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Tleus DUE TO (b) Diveriticulitis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 wks Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Operation for lung lesion 3 wks prior to death			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
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.)	
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
21. I attended the deceased from Oct 11, 1960 to Nov 29, 1960 and last saw him alive on Nov 29, 1960 Death occurred at 11:50 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Daniel G. Hester M.D.		22b. ADDRESS 634 N. Grand Ave	22c. DATE SIGNED 12-2-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/3/1960	23c. NAME OF CEMETERY OR CREMATORY Borromeo, Cemetery	23d. LOCATION (City, town, or county) (State) St. Charles, Missouri
24. FUNERAL DIRECTOR ADDRESS Arthur C. Baue, Inc. St. Charles, Mo.	25. DATE RECD. BY LOCAL REG. 12-2-60	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Dan Sexton

Missouri Theatre Bldg.

JE 1 1750

MAY 16 1961

JUL 13 1961

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 Arthur C. Bane

Licensed Embalmer No. 3155
P. O. Address H. Charles

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.