

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-044770

FILED VS. NOV 28 1960 317

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3320

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		c. CITY OR TOWN Crestwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunset Nurs. Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 9501 Eudora Ct.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MINNIE Middle L. Last TAYLOR				4. DATE OF DEATH Month Nov. Day 15, Year 1960						
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/12/97	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) Unk. Missouri		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME James H. Jones			13b. MOTHER'S MAIDEN NAME Sarah Jackson			14. NAME OF HUSBAND OR WIFE unk.				
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. 495 28 9488		17. INFORMANT Evelyn Cobb, 9501 Eudora Ct. Address Crestwood, 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) Chronic Pyelonephritis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebro-vascular accident, old.						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ 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
21. I attended the deceased from April 22, 1960 to Nov. 15, 1960 and last saw her alive on Nov. 8, 1960 Death occurred at Ellisville, Mo. 6:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) George E. Smith, M.D.				22b. ADDRESS 325 N. Kirkwood Rd. Kirkwood 22, Mo.				22c. DATE SIGNED 11-15-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/17/60	23c. NAME OF CEMETERY OR CREMATORY St. Trinity			23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.				
24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette(4) ADDRESS				25. DATE RECD. BY LOCAL REG. 11-15-60		26. REGISTRAR'S SIGNATURE Johanna Murphy M.D.				

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.