

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044776

LED J5 NOV 17 1960 317 Registration District No. Primary Registration District No. 500 Registrar's No. 3140 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch		Length of stay in 1b 43 days	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rob't. Koch Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Hodimont & Page Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Herman Middle W. Last Vanderbos	4. DATE OF DEATH Month 10 Day 28 Year 60
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3.31-93	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY Electrical	11. BIRTHPLACE (City and state and country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Jacob Vanderbos	13b. MOTHER'S MAIDEN NAME Mary Geretzen	14. NAME OF HUSBAND OR WIFE none
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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. 498-16-8944	17. INFORMANT Rob't, Koch Hospital, Koch, Mo.
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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) Cor Pulmonale	INTERVAL BETWEEN ONSET AND DEATH 2-3 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bronchial Asthma	40 years
DUE TO (c) Pulmonary Emphysema	10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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 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.)
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20c. TIME OF INJURY Hour 8:50 A.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 9-15-60 to 10-28-60 and last saw her/him alive on 10-27-60 Death occurred at 8:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Axel R. Loran, M.D.	22b. ADDRESS Robert Koch Hospital	22c. DATE SIGNED 10-28-60
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23a. BURIAL, CREMATION, or other disposal (Specify)	23b. DATE October 31, 1960	23c. NAME OF CEMETERY OR CREMATORY Assumption Cemetery	23d. LOCATION (City, town, or county) (State) Missouri
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24. FUNERAL DIRECTOR O'Fallon Mortuary Inc Charles J. Callahan	25. DATE RECD. BY LOCAL REG. 10-29-60	26. REGISTRAR'S SIGNATURE John B. Murphy, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 8 1962

NOV 17 1960

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 Charles J. Callahan

Licensed Embalmer No. Permit

P. O. Address O'Fallon

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.