

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048339

FILED VS DEC 19 1960

Registration District No. 317 Primary Registration District No. 59050 Registrar's No. 3574 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Manchester Mo.</u>		Length of stay in 1b <u>2 wks.</u>	c. CITY OR TOWN <u>Wellston</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pine Crest Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6320 Wagner</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>Ison</u> Last <u>Ison</u>			4. DATE OF DEATH Month <u>December</u> Day <u>7-</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/7/99</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Preacher - Porter</u>		11. BIRTHPLACE (City and state or country) <u>ST. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>HARRY Ison</u>		13b. MOTHER'S MAIDEN NAME <u>Viola Adams</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—————</u>	17. INFORMANT <u>PINECREST RECORDS</u> Address		

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) <u>Hepatic insufficiency</u>		
DUE TO (b) <u>metastatic carcinoma in liver</u>		
DUE TO (c) <u>Bronchiogenic Carcinoma</u>		
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

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 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 <u>Oct 18 - 1960</u> to <u>Nov 28, 1960</u> and last saw her/him alive on <u>Nov 28, 1960</u>			
Death occurred at <u>9:35 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Albert L. Howe M.D.</u> (Degree or title)		22b. ADDRESS <u>601 S. Brentwood Bl.</u>	22c. DATE SIGNED <u>12/8/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-13-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson</u>	23d. LOCATION (City, town, or county) (State) <u>Kirkwood Mo</u>
24. FUNERAL DIRECTOR <u>A. L. Beal Und. Co.</u> ADDRESS <u>4303 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>12-12-60</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy M.D.</u>

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arthur L. Herliand

Licensed Embalmer No. 4221
P. O. Address 31006 as

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.