

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961

-60-048347

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3707

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>—</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KOCH</u>		Length of stay in Tb <u>7 days</u>		c. CITY OR TOWN <u>ST LOUIS</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ROBT KOCH HOSP</u>			Inside Units <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		d. STREET ADDRESS (If outside, give location) <u>1234 DILLON DR</u>		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>Frank</u> Last <u>MARTIN</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-20-82</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>employee</u>		11. BIRTHPLACE (City and state or country) <u>AUSTIN TEXAS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>VIRGIL MARTIN deceased</u>			13b. MOTHER'S MAIDEN NAME <u>EMMA FLOOD deceased</u>		14. NAME OF HUSBAND OR WIFE <u>MAGGIE MARTIN deceased</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>ROBT KOCH HOSPITAL RECORDS</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) <u>CORONARY ARTERY SCLEROSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CIRRHOSIS OF LIVER (LAFFNEC'S)</u>					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 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 <u>—</u> a.m. <u>—</u> 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 <u>Dec 20 / 60</u> to <u>Dec 26 / 60</u> and last saw <u>him</u> alive on <u>Dec 26 / 60</u> Death occurred at <u>3:45</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Frank Cohen MD</u>				22b. ADDRESS <u>Robt Koch Hosp Koch MO</u>		22c. DATE SIGNED <u>12/26/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>WACKER-HELDERLE-3634 Gravois Ave.</u>				25. DATE RECD. BY LOCAL REG. <u>12-27-60</u>		REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

7011

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 Philip J. Krupinski

Licensed Embalmer No. 3497

P. O. Address St. Louis

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.