

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961
 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3778 60-048348
STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>ST LOUIS</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KOCH</u>		a. STATE <u>MO</u>		b. COUNTY <u>---</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		Length of stay in lb <u>267 days</u>		c. CITY OR TOWN <u>St Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give address) <u>Little Lutesy of Poor - So Grand</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>JAMES</u>		Middle <u>MAYNARD</u>		Last <u>MAYNARD</u>		Month <u>Dec</u> Day <u>27</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>2-21-71</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUTCHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MEAT MARKET</u>		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>THOMAS MAYNARD</u>		13b. MOTHER'S MAIDEN NAME <u>HARRIETT ?</u>		14. NAME OF HUSBAND OR WIFE <u>GRACE SMOOT</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>490-26-0839A</u>		17. INFORMANT <u>Hospital Record, Robert Koch Hospital</u>			
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>Bronchopneumonia</u>							
DUE TO (b) <u>Carcinoma of the Pancreas</u>							
DUE TO (c) _____							
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 _____					
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 _____ to _____ and last saw him alive on _____		Death occurred at _____ P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Frank Cohen MD</u> (Degree or title)				22b. ADDRESS <u>Robert Koch Hospital Koch</u>		22c. DATE SIGNED <u>Dec 12/28/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC 30, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CONCORDIA</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MISSOURI</u>	
24. FUNERAL DIRECTOR <u>BEIDERWIEDEN FUNERAL HOME</u>		ADDRESS <u>936 ST. LOUIS AVE</u>		25. DATE RECD. BY LOCAL REG. <u>12-29-60</u>		REGISTRAR'S SIGNATURE <u>John B. Murphy MD</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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

David R. [Signature]

Licensed Embalmer No. 452

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.