

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-003919

FILED VS JAN 16 1961

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 18

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton			Length of stay in 1b DOA		c. CITY OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6600 Washington		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Emil Middle Joseph Last Munier			4. DATE OF DEATH Month January Day 1 Year 1961					
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 3/11/1879	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carotaker		10b. KIND OF BUSINESS OR INDUSTRY Old Peoples Home		11. BIRTHPLACE (City and state or country) O'Fallon, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.		
13a. FATHER'S NAME Hyacinth Peters Munier		13b. MOTHER'S MAIDEN NAME Anna Hess		14. NAME OF HUSBAND OR WIFE None				
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. None		17. INFORMANT Address Mrs. Myrtle Sprague, 6600 Washington				
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) Penetrating gunshot wound of the brain								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) _____								
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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input checked="" type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Self inflicted gunshot wound of head				
20c. TIME OF INJURY Hour 7:15 a.m. Month, Day, Year 1/1/61		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home for the Aged		20f. CITY, TOWN, OR LOCATION COUNTY STATE University City St. Louis Missouri		
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Raymond Shaw</i> Coroner Clayton, Mo.				22b. ADDRESS		22c. DATE SIGNED 1/5/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 1-3-61		23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. 1-3-61		26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>		

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 _____
Not Embalmed
Lawrence E. Meyer

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.