

**SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

318

1003

1376

61-006614

STATE FILE NUMBER

AMENDED

Registration District No. FILED VS FEB 28 1961

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>CITY HOSP.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1907 MC CAUSLAND</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>J</b> Last <b>JORGENSEN</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>APR. 21, 1899</b>	9. AGE (last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NIGHT WATCHMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GRIVES LAB. CO.</b>		11. BIRTHPLACE (City and state or country) <b>WISCONSIN</b>		12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>	
13a. FATHER'S NAME <b>UNK.</b>		13b. MOTHER'S MAIDEN NAME <b>UNK.</b>		14. NAME OF HUSBAND OR WIFE <b>MARIAN JORGENSEN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARIAN JORGENSEN 1907 MC CAUSLAND</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hemorrhage caused by fracture of skull, abdominal hemorrhage (lower) caused by fractured pelvic bone. Suffered when struck by car operated by one Raymond Noble, in park of about 1420 Clark ave., on Feb. 9th 1961, at about 8:45 a.m.</b> DUE TO (b) <b>ACCIDENT</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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.) <b>See above</b>				
20c. TIME OF INJURY Hour <b>8:45</b> a.m. p.m. Month, Day, Year <b>2-9-61</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>						
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo</b>		COUNTY		STATE		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ <b>1050 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Paul J. Simon</b> (Degree <b>Asst. Coroner</b> )				22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>2/10/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>REMOVAL</b>		<b>FEB 13, 1961</b>		<b>NATIONAL CEMETERY</b>		<b>JEFFERSON BARRACKS MO.</b>	
24. FUNERAL DIRECTOR <b>Thomas Kutas 2906 Grovois</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>FEB 10 1961</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>	

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 1 4 1982

**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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 groves

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.