

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-007152
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 518

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED VS MAR 2 1961

1. PLACE OF DEATH
a. COUNTY **St. Louis**
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **Jennings** Length of stay in 1b **YRS**
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION **8952 Mayfield** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo.** b. COUNTY **St. Louis**
c. CITY OR TOWN **Jennings** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **8952 Mayfield** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **PETER** Middle **A.** Last **IMMING**

4. DATE OF DEATH Month **2** Day **20** Year **61**

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **9/26/1883** 9. AGE (last birthday) **77 yrs.** IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) **Illinois** 12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **Herman Imming** 13b. MOTHER'S MAIDEN NAME **Mary Deister** 14. NAME OF HUSBAND OR WIFE **Lillian Prior Imming**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No** 17. INFORMANT Address **Lillian Imming 8952 Mayfield Ct.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **CORONARY OCCLUSION**
DUE TO (b) **ARTERIOSCLEROTIC HEART DISEASE**
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 2/14/61 to 2/20/61 and last saw her/him alive on 2/18/61
Death occurred at 10:05 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *Carl W. Lanning, M.D.* 22b. ADDRESS **6000 W. Florissant Ave.** 22c. DATE SIGNED **2/20/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **2/23/61** 23c. NAME OF CEMETERY OR CREMATORY **Bellefontaine** 23d. LOCATION (City, town, or county) (State) **St. Louis, Mo.**

24. FUNERAL DIRECTOR **E.J. Schnur** ADDRESS **3125 Lafayette Ave.** 25. DATE RECD. BY LOCAL REG. **2-21-61** 26. REGISTRATION SIGNATURE *James W. Murphy, M.D.*

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 Thomas R. Demwick

Licensed Embalmer No. 3793

P. O. Address 3125 Lafayette

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.