SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-015962
STATE FILE NUMBER

AMENDED ✓ Registration District No. 317 Primary Registration District No. 531 Registrar's No. 1065

FILED APR 24 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: University City — Length of stay in 1b: 4 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 6252a Olive St. Rd. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: University City — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 6252a Olive St. Rd. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Homer Last: McDaniel
4. DATE OF DEATH: Month: April Day: 18, Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6/18/1900
9. AGE (last birthday): 60 — 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): Self Employed-Retired
10b. KIND OF BUSINESS OR INDUSTRY: Storm Windows
11. BIRTHPLACE (City and state or country): Illinois
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Harvey McDaniel
13b. MOTHER'S MAIDEN NAME: Elizabeth Mangum
14. NAME OF HUSBAND OR WIFE: Gertie M. McDaniel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Address: Mrs. Gertie McDaniel, 6252a Olive St. Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
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. ☐ 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 June 10, 1945 to april 18, 61 and last saw her/him alive on march 16, 61
Death occurred at 9:55 am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Michael Sulick M.D.
22b. ADDRESS: 9012 Manchester Rd.
22c. DATE SIGNED: 4-18-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 4-18-61
23c. NAME OF CEMETERY OR CREMATORY: Local Cemetery
23d. LOCATION (City, town, or county) (State): Dexter, Mo.

24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe, Inc., 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: 4-18-61
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. L.

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.