

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026386

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 310 Primary Registration District No. 6051 Registrar's No. 150

STATE FILE NUMBER

AMENDED

FILED JUL 6 1961

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

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>rural-St.Chas.twsp.</u>		Length of stay in 1b <u>19 Yrs.</u>	c. CITY OR TOWN <u>rural-St.Chas. twsp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1703 So. River Rd.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1703 So. River Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>William</u> Last <u>Jose</u>			4. DATE OF DEATH Month <u>Jun.</u> Day <u>22</u> Year <u>1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1900</u>
9. AGE (last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>25</u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (City and state or country) <u>St. Charles, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Michael M. Jose</u>	
13b. MOTHER'S MAIDEN NAME <u>Susie Fitz</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Saulter</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>UNKNOWN</u>	17. INFORMANT <u>Mrs. Mary Jose, St. Charles, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (b) <u>Arterio-sclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Emphysema</u>			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 type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m.	Month, Day, Year <u> </u> <u> </u> <u> </u>	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.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u>1954</u> to <u>June 23, 1961</u> and last saw him alive on <u>June 23, 1961</u> Death occurred at <u>4:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Don Z. Randall, M.D.</u>		22b. ADDRESS <u>220 S. 6th St. Charles, Mo.</u>	22c. DATE SIGNED <u>June 24, 1961</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jun. 25, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>
24. FUNERAL DIRECTOR <u>H.C. Dallmeyer & Sons, St. Charles, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>JUNE 24-61</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>

JUL 14 1961

5/11

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

Licensed Embalmer No. 4832

P. O. Address: St Charles

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.