

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**61-031318**

STATE FILE NUMBER

AMENDED

Registration District No. **317**

Primary Registration District No. **500**

Registrar's No. **2296**

**FILED AUG 28 1961**

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>INDIANA</b> b. COUNTY <b>VIGO</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MISSOURI</b>		Length of stay in 1b <b>710 DAYS</b>		c. CITY OR TOWN <b>TERRE HAUTE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>614 N. 12TH STREET</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>JOSEPH</b> Last <b>HALEY</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-17-92</b>	9. AGE (last birthday) <b>69</b>	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) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (City and state or country) <b>TERRE HAUTE, IND.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOHN JOSEPH HALEY</b>			13b. MOTHER'S MAIDEN NAME <b>KATERINE (UNKNOWN)</b>		14. NAME OF HUSBAND OR WIFE <b>NEVER MARRIED</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>MARY O'MALLEY (SISTER)</b> Address <b>416 S. 22ND TERRE HAUTE, IND.</b>				
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>CORONARY THROMBOSIS, ACUTE</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>6 MOS</b>
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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____						
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.) <b>V.A.</b>		20f. CITY, TOWN, OR LOCATION <b>TERRE HAUTE</b>		COUNTY	STATE
21. I attended the deceased from _____ to _____ Death occurred at <b>1:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>RICHARD E. DANIELS, M.D.</b>				22b. ADDRESS <b>VET ADM HOSP, JEFF BRKS 25, MO.</b>		22c. DATE SIGNED <b>8-12-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8/14/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Terre Haute, Indiana</b>		23d. LOCATION (City, town, or county) (State) <b>Terre Haute, Indiana</b>			
24. FUNERAL DIRECTOR <b>Edward Fendler 5611 So. Grand Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>8-14-61</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>		

**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 Lea J. Budd

Licensed Embalmer No. 3989

P. O. Address St. Louis, Mo.

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.