

# SOURI DIVISION OF HEALTH - GRAND CERTIFICATE OF DEATH

-61-046017

DEPARTMENT OF PUBLIC HEALTH AND WELFARE XC-

SL 27371

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12345

AMENDED

FILED JAN 1 1962

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>915 N. Grand, St. Louis, Mo.</u> Length of stay in 1b <u>7 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET. ADM. HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>  c. CITY OR TOWN <u>Steelville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>GENERAL DELIVERY</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) <u>SAMUEL W. AGERS</u>	<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>30</u> Year <u>1961</u>
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<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/23/94</u>	<b>9. AGE (last birthday)</b> <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>---</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>De Soto, Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
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<b>13a. FATHER'S NAME</b> <u>UNKNOWN</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>MYRTLE AGERS</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWII</u>	<b>17. INFORMANT</b> Address <u>CHESTER AGERS, SEE # 2d</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO (b) <u>INTRACEREBRAL VASCULAR ACCIDENT</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>  <u>7 DAYS</u>
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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
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>
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<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY _____	STATE _____
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21. VA attended the deceased from 12/23/61 to 12/30/61 and last saw him alive on 12/30/61  
 Death occurred at 1:50 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <u>Theodore C. Goodfriend, M.D.</u> (Degree or title)	<b>22b. ADDRESS</b> <u>VAH, ST. LOUIS, MO.</u>	<b>22c. DATE SIGNED</b> <u>12-30-61</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>REMOVAL</u>	<b>23b. DATE</b> <u>12-30-1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Johns</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>GRANITE CITY, ILLINOIS</u>
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<b>24. FUNERAL DIRECTOR</b> <u>Mercer Funeral Home</u> ADDRESS <u>Granite City, Ill.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>JAN 2 1962</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Lead Smith M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

**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 Shirton C. Shellman

Licensed Embalmer No. 5016

P. O. Address Granite City

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.