

MISSOURI - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046451

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

11860

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED JAN 5 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3966 Randall</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3966 Randall</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Stephen</b> Middle <b>Jaby</b> Last			4. DATE OF DEATH Month <b>December</b> Day <b>17</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-29-1905</b>	9. AGE (last birthday) <b>56</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Utility Man, Police Dept.</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>Jaby</b>	13b. MOTHER'S MAIDEN NAME <b>Unk</b>	14. NAME OF HUSBAND OR WIFE <b>Oliver Jaby</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>no none</b>	16. SOCIAL SECURITY NO. <b>unk.</b>	17. INFORMANT <b>Grace DeBisschop 7819a Pa., St. Louis</b>	Address <b>Missouri</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Gunshot wound of head, suffered when shot with gun in hands of one Oliver Jaby, wife of deceased, while suffering a mental aberration on home December 17, 1961. exact time unknown.**

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 directed to the terminal disease condition given in PART I (a) **accident**

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>see above</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <b>12-17-61</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>15 Home</b>	20f. CITY, TOWN, OR LOCATION <b>St Louis, Mo</b>	COUNTY	STATE
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **12<sup>16</sup> P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Helen L. Taylor, Coroner</b>	22b. ADDRESS <b>1300 Clark Ave.</b>	22c. DATE SIGNED <b>12-19-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>12-21-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Lemay, Mo.</b>
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24. FUNERAL DIRECTOR <b>Southern Funeral Home 6322 S. Grand, St. Louis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 19 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

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

*David Van Rosen*

Licensed Embalmer No. 4242

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.