

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047218

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3575

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST. LOUIS</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>VALLEY PARK</u>	a. STATE <u>Mo</u>	b. COUNTY <u>ST. LOUIS</u>
Length of stay in lb <u>13 YRS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VALLEY PARK NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>UNKNOWN</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <u>IRENE</u>	Middle <u>RUTH</u>	Last <u>HITTE</u>	Month <u>DEC</u>	Day <u>16</u> Year <u>1961</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-26-94</u>	9. AGE (last birthday) <u>67</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	11. BIRTHPLACE (City and state or country) <u>DECATUR, ILL</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>ALBERT CRUNELLE</u>	13b. MOTHER'S MAIDEN NAME <u>MARIE STRADIE</u>	14. NAME OF HUSBAND OR WIFE <u>—</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>	17. INFORMANT <u>RECORD OF VALLEY PARK NURSING HOME</u> Address <u>PARKY MO</u>
--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>13 years</u>
IMMEDIATE CAUSE (a) <u>Multiple Sclerosis</u>	DUE TO (b) _____	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	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. <input type="checkbox"/> Yes <input checked="" 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.)
--	---	--

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.)	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
--	--	---

21. I attended the deceased from Sept. 19, 1960 to Dec. 16, 1961 and last saw her him alive on Dec. 14, 1961
 Death occurred at 7:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert D. Sanders, M.D.</u> (Degree or title)	22b. ADDRESS <u>1502 Case Av. St. Louis</u>	22c. DATE SIGNED <u>12-16-61</u>
---	---	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE <u>DEC 18, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUND</u>	23d. LOCATION (City, town, or county) (State) <u>PANA TWP ILL</u>
--	-------------------------------	---	---

24. FUNERAL DIRECTOR <u>G. J. Kennedy</u> ADDRESS <u>PANA, ILL</u>	25. DATE RECD. BY LOCAL REG. <u>12-16-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy, M.D.</u>
--	--	---

D.J. KENNEDY & SONS - PANA. (Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 NOT EMBALMED, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed M. J. Kennedy

Licensed Embalmer No. 7063

P. O. Address PANA, ILL

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.