

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016450

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 111

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 3 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Charles</u>	a. STATE <u>Mo</u>	b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>	Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>O'Fallon</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>St. Josephs Hosp</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>115 Front St.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Cletus</u> Middle <u>John</u> Last <u>Orf</u>	4. DATE OF DEATH	Month <u>April</u> Day <u>15</u> Year <u>1962</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</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>12/6/1895</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months		Days
				Hours		Min.

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>ref. Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (City and state or country) <u>O'Fallon, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Anton Orf</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Roettger</u>	14. NAME OF HUSBAND OR WIFE <u>Berniece Goellner</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. 	17. INFORMANT <u>Berniece Orf</u> Address <u>O'Fallon, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 mos.</u>
IMMEDIATE CAUSE (a) <u>CARCINOMA TOSIS</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CARCINOMA of the STOMACH</u>	
	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 type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY	Hour	Month, Day, Year
	a.m. p.m.	

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
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21. I attended the deceased from 2-28-61 to 4-14-62 and last saw him alive on 4-14-62
Death occurred at 8:07 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Gene J. DuMontre</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>O'Fallon, Mo</u>	22c. DATE SIGNED <u>4-17-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/19/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Assumption Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>O'Fallon, Mo</u>
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24. FUNERAL DIRECTOR <u>Keithly-Davis Chapel</u> ADDRESS <u>O'Fallon, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4/20/62</u>	26. REGISTRAR'S SIGNATURE <u>Mareeela Wilson</u>
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USE BLACK INK OR TYPEWRITER RIBBON

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 *Gerry A. Davis*
Licensed Embalmer No. 5139

P. O. Address *O'Fallon, 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.