

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-020510
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1949
FILED JUL 30 1962

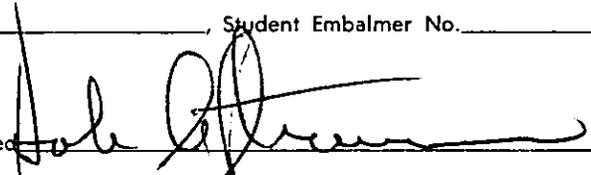
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| VS 300 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT | MEDICAL CERTIFICATION | BY AFFIDAVIT OF | SHOULD READ | ITEM NO. |
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| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Hts. | | Length of stay in lb 3 1/2 Mon. | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS 4910 West Pine Blvd. Forest Park Hotel | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) PAUL W. LAYMAN | | | | 4. DATE OF DEATH July 1, 1962 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 12-31-1906 | | |
| 9. AGE (last birthday) 55 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store manager | | 10b. KIND OF BUSINESS OR INDUSTRY Drugstore | | 11. BIRTHPLACE (City and state or country) Metropolis, Ill. | | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Roy Layman | | 13b. MOTHER'S MAIDEN NAME Margaret Weekley | | 14. NAME OF HUSBAND OR WIFE Margaret Layman | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Margaret Layman, 4910 West Pine Blvd. | | |
| 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 | |
| IMMEDIATE CAUSE (a) Carcinomatous | | | | DUE TO (b) Carcinoma of soft palate | | DUE TO (c) | | 3 months |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | 1 yr |
| 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 | | |
| 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 1950 to July 1-1962 and last saw him alive on July 1 1962 Death occurred at 10:05A on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <i>Fred Kramer M.D.</i> (Degree or title) | | | | 22b. ADDRESS 4161 Lundeel | | 22c. DATE SIGNED 7-2-62 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 7-3-1962 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery | | 23d. LOCATION (City, town, or county) Centralia, Illinois (State) | | |
| 24. FUNERAL DIRECTOR Kriegshauser 9450 Olive St. Road ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. 7-2-62 | | 26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i> | | |

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  _____

Licensed Embalmer No. 4533

P. O. Address _____

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.