

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036996

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2605

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Randolph</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>RICHMOND HEIGHTS</b>		Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>Chester</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>509 W. German St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ERNEST G. DECKER</b>			4. DATE OF DEATH Month Day Year <b>Sept. 6, 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-24-09</b>
9. AGE (last birthday) <b>52</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Co-owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	11. BIRTHPLACE (City and state or country) <b>Chester, Ill.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Henry Decker</b>	
13b. MOTHER'S MAIDEN NAME <b>Ida Kraft</b>		14. NAME OF HUSBAND OR WIFE <b>Joyce</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not Available</b>	
17. INFORMANT <b>Mrs. Joyce Decker, Chester, Ill.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissecting Aneurysm Aortic Arch</b> 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 not related to the terminal disease condition given in PART I (a) <b>Coronary Artery Thrombosis &amp; Cerebral Insuffic.</b> 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 Month, Day, Year a.m. p.m.			
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.)	20f. CITY, TOWN, OR LOCATION <b>9-5-62 to 9-6-62</b>	COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Frank A. Palazzo MD</b> (Degree or title)		22b. ADDRESS <b>4161 Lindell Blvd.</b>	22c. DATE SIGNED <b>9-6-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>VEGETARIAN</b>	23b. DATE <b>9-8-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Lutheran</b>	23d. LOCATION (City, town, or county) (State) <b>Chester, Ill.</b>
24. FUNERAL DIRECTOR <b>Welge Funeral Home, Chester, Ill.</b>		25. DATE RECD. BY LOCAL REG. <b>9-7-62</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy MD</b>

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 John J. Kossly III

Licensed Embalmer No. 5039

P. O. Address E St Louis

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.