

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040358

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

XC-1844 247 SL 12951

10592

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No.

FILED NOV 13 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

83

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | | | | |
|---|--|--|---|--|-----------------------|---|----------------------------------|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. Grand, St. Louis, Mo. | | Length of stay in 1b 1 hr. 40 min. | | c. CITY OR TOWN Granite City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY | | c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS 4110 Lake Drive | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle W. Last HURT | | | 4. DATE OF DEATH Month November Day 4 Year 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 8/3/87 | | 9. AGE (last birthday) 75 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HR Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | |
| 10b. KIND OF BUSINESS OR INDUSTRY Engineering Depot. | | 11. BIRTHPLACE (City and state or country) Venice, Illinois | | 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME John Hurt | | 13b. MOTHER'S MAIDEN NAME ret. 10 years Caroline Kolemayer | | |
| 14. NAME OF HUSBAND OR WIFE Edith Hurt | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1 | | 17. INFORMANT Address Edith Hurt (Wife), Same add. as 2. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma Left Lung | | INTERVAL BETWEEN ONSET AND DEATH 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 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 checked="" type="checkbox"/> NO <input 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 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 11/4/62 to 11/4/62 and last saw him alive on 11/4/62 | | |
| 21. Death occurred at 4:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE B. G. SMITH (Degree of title) | | 22b. ADDRESS VAH, ST. LOUIS, MO. | | 22c. DATE SIGNED 11/4/62 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | |
| 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) | | 23e. (State) | | 24. FUNERAL DIRECTOR Francis J. Fahay Madison ADDRESS | | |
| 25. DATE RECD. BY LOCAL REG. NOV 5 1962 | | REGISTRAR'S SIGNATURE Boyd Smith, M.D. | | 25. DATE RECD. BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 25. DATE RECD. BY LOCAL REG. | | |

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 Francis J. Jolley

Licensed Embalmer No. 2792

P. O. Address Medison Rd.

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.