

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-048058

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 306 Primary Registration District No. 6049 Registrar's No. 73

FILED JAN 2 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

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>O'Fallon</u>		c. CITY OR TOWN <u>O'Fallon</u>	
Length of stay in lb <u>3 yrs</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>Main &amp; Church Sts.</u>		d. STREET ADDRESS (If outside, give location) <u>18 St. Paul Ct.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence E. Fine</u>			4. DATE OF DEATH Month Day Year <u>Dec. 27, 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-1920</u>
9. AGE (last birthday) <u>42</u>		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) <u>Pipe Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Utility</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Charles I. Fine</u>	
13b. MOTHER'S MAIDEN NAME <u>Rose M. Gallagher</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>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Mrs. Robert Roellig</u>		Address <u>O'Fallon, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Natural causes Apparent Coronary Occ</u>			<u>1 min.</u>
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 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.) <u>Man collapsed at Standard Service Station, pronounced dead by physician there</u>	
20c. TIME OF INJURY Hour <u>5:45</u> Minute <u>xxx</u> Month, Day, Year <u>12/27/62</u>	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.) <u>Service station</u>		20f. CITY, TOWN, OR LOCATION <u>O'Fallon</u>	COUNTY <u>St. Charles</u> STATE <u>Mo.</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____			
Death occurred at <u>3:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>E. Keithly Registrar</u>		22b. ADDRESS <u>O'Fallon Mo</u>	22c. DATE SIGNED <u>12/29/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>Dec 29, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>Keithly-Davis Funeral Hm</u>		ADDRESS <u>O'Fallon</u>	25. DATE RECD. BY LOCAL REG. <u>12/29/62</u>
			26. REGISTRAR'S SIGNATURE <u>E. Keithly</u>

USE BLACK INK OR TYPEWRITER RIBBON

JAN 3 1968

**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 Jerry A. Davis

Licensed Embalmer No. 5739

P. O. Address Fallon, Ma

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.