

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042414

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3267

FILED OCT 30 1963 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON, Mo.</u>		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. CITY OR TOWN <u>Affton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u># 16 Heather Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR E. ROBERT</u>			4. DATE OF DEATH Month Day Year <u>Oct. 23 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>7/4/1900</u>
9. AGE (last birthday) <u>63</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>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware Store</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>Carl Robert</u>	
13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Robert</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>		17. INFORMANT Address <u>Margaret Robert # 16 Heather</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion, acute</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
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 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 <u>Oct 5 1963 to Oct 25 '63</u>	COUNTY STATE <u>10/22/63</u>
21. I attended the deceased from <u>9:15 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William T Jiggsveld MD</u>		22b. ADDRESS <u>3915 WATSON RD</u>	
22c. DATE SIGNED <u>10/24/63</u>		23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>10/26/1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>		24. FUNERAL DIRECTOR ADDRESS <u>John L. Zeigenhein &amp; Sons 7027 Gravois</u>	
25. DATE RECD. BY LOCAL REG. <u>10-24-63</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u>	

VS 300 Rev. 4/59	AMENDED	DATE AMENDED	ITEM NO.	SHOULD READ	BY AFFIDAVIT OF	DOCUMENT	MEDICAL CERTIFICATION
1/002		2	2	40/27	3	4	0
5		6	7	0	8	2	94201
10		11	12	92-7	13		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF OHIO

**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 Donald Biny

Licensed Embalmer No. 4863

P. O. Address John Doe

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.