

pt. Health,
, & Welfare
S. Public
lth Service

FILED DEC 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41989
STATE FILE NUMBER
11856

Registration District No. 318 Primary Registration District No. 1003

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY		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 St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hosp.		d. STREET ADDRESS 3406 Macklind Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last VIRGIL M. FURRY		4. DATE OF DEATH Month Day Year Dec. 9 1957	
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 Feb. 27, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype Operator-Globe Democrat		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Greenville, Ill.
13a. FATHER'S NAME Delbert M. Furry		13b. MOTHER'S MAIDEN NAME Stelle Weiss	14. NAME OF HUSBAND OR WIFE Victorine J. Furry
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War 2		16. SOCIAL SECURITY NO. -	17. INFORMANT Address Victorine J. Furry 3406 Macklind Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia bilateral lobar			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			490x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 12-7-57 to 12-9-57 and last saw her alive on 12-8-57 Death occurred at 5:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) R. Nachmeyer M.D.		22b. ADDRESS 4065 S. Grand	22c. DATE SIGNED 12/10/57
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12-10-1957	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Millerburg, Ill.
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. DEC 10 57	26. REGISTRAR'S SIGNATURE J. Carl Smith Mo -mfs

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Richard W. Storren*

Licensed Embalmer No. *4007*

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.