

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45754  
STATE FILE NUMBER  
12457

FILED JAN 13 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar No. 12457

S. 300  
v. 1-56

Recording the medical certification in the specific manner required by 193.140 MoRS 1949.  
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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Jeff.</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST LOUIS</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>HIGH RIDGE</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>FIRMIN DESLOGE</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>29 CARELTON DR</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Robert J Devine</i>			4. DATE OF DEATH Month <i>12</i> Day <i>26</i> Year <i>1957</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 12-1877</i>	9. AGE (In years last birthday) <i>80</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life—seen if retired) <i>STATIONARY FIREMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>LAUNDRY</i>	11. BIRTHPLACE (City and state or country) <i>St Charles Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Michael Devine</i>			14. MOTHER'S MAIDEN NAME <i>Agnes Truesdale</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>486-03-4655</i>	17. INFORMANT Address <i>MAY E DEVINE HIGH RIDGE MO</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i>					INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUPLICATE TO (b) <i>Chronic glomerulonephritis</i>					
DUPLICATE TO (c) <i>Urteral obstruction</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>603X</i>					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 <i>a. m.</i> Month, Day, Year <i>p. m.</i>					
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 <i>12-24-57</i> to <i>12-26-57</i> and last saw her alive on <i>12-26-57</i> Death occurred at <i>1:30 AM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>J. Saloner</i> (Degree or title) <i>MD</i>		22b. ADDRESS <i>1325 S. Grand Av</i>		22c. DATE SIGNED <i>12/26/57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>12-28-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Vault Halla Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>St Louis County Mo</i>
24. FUNERAL DIRECTOR <i>BRIMMER FUNERAL HOME</i>		ADDRESS <i>House Springs Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>DEC 26 57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, MD</i> <i>mjb</i>

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.....  
Harvey Kahle  
Licensed Embalmer No. 4596  
P. O. Address Florissant

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.