

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022609

STATE FILE NUMBER

FILED JUN 23 1959

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 238

health, welfare, public service, 300, 1-56, All diseases in Part 1 must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part 1 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 <u>St. Francois County</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Grant</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural St. Francois</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Marion</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mineral Area Osteopathic Hospital</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jesus</u> Middle _____ Last <u>DeLaCerde</u>			4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Mexican</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>June 16, 1959</u>	9. AGE (In years last birthday) Months _____ Days _____ Hours <u>1</u> Min. <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jesus DeLaCerde</u>			14. MOTHER'S MAIDEN NAME <u>Eloisa Medina</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>None</u>	17. INFORMANT Address <u>Jesus DeLaCerde, Marion, Indiana</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>Anoxia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Premature Birth (7 months)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>7625</u>
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 <u>7:00 a.m.</u> to <u>8:25 a.m.</u> <u>6-16-59</u> and last saw him ^{her} alive on <u>6-16-59</u> Death occurred at <u>8:25 a.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Stank N. Glick, D.O.</u>		22b. ADDRESS <u>Ste. Genevieve, Mo.</u>	22c. DATE SIGNED <u>6-18-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>June 17, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Calvary Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Farmington, Missouri</u>		
24. FUNERAL DIRECTOR <u>Millers Funeral Home, Farmington, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>June 19, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>		

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... *Paul H. Royal*.....

Licensed Embalmer No. *412*

P. O. Address *Farmington*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.